1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08626 — 08606

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4711 Derussey [illegible] Pkwy

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Chevy Chase
d. STREET ADDRESS: 4711 DeRussey [illegible] Pkwy
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Clara — Middle: Delp — Last: Anderson
4. DATE OF DEATH: Month: Aug. — Day: 4, — Year: 1957 19

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/16/75
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles H. Delp
14. MOTHER'S MAIDEN NAME: Anna E. Spangenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Arthur D. Anderson, Same as Item #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Secondary anemia 30 yrs.
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/4/57
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/7/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln
22d. LOCATION (City, town, or county) (State): Prince Geo Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 8-7-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

08627 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 08607

Item 9, Film G219, 8/23/57 **CERTIFICATE OF DEATH** Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD2 Germantown
c. LENGTH OF STAY IN 1b 45 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RD2 Germantown xl
d. STREET ADDRESS RD2 Germantown
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Mamie Middle Elizabeth Last Anderson
4. DATE OF DEATH Month Aug. Day 15 Year 1957
5. SEX F
6. COLOR OR RACE Col.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Sept. 23 1881
9. AGE (In years last birthday) 75 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Seneca, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Goldie Driver
14. MOTHER'S MAIDEN NAME Harriet N. Driver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Clara Green, Sister, RD2 Germantown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 7 Mos?
420.1
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Congestive Heart Failure
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-6, 1957, to 8-15, 1957, that I last saw the deceased alive on 8-15, 1957, and that death occurred at 5:15 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Clive E. Jackson, M.D. M.D. ADDRESS (Street, city or town, state) RD1 Gaithersburg, Md. DATE SIGNED 8-15-57
PHYSICIAN'S NAME (Type) C. LIVE E. JACKSON

22a. BURIAL CREMATION REMOVAL (Specify) Burial
22b. DATE THEREOF 8-18-57
22c. NAME OF CEMETERY OR CREMATORY Seneca,
22d. LOCATION (City, town, or county) (State) Seneca, Md

23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Saunders ADDRESS Rockville, Md.
24c. REC'D BY REGISTRAR DATE AUG 20 1957
24b. REGISTRAR'S SIGNATURE Woodrow G. Cooke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08628

CERTIFICATE OF DEATH

08608

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 914 PHILADELPHIA AVE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 56 SILVER SPRING
d. STREET ADDRESS: 914 PHILA. AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle E Last ANDERSON
4. DATE OF DEATH: Month AUGUST Day 1 Year 1957
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 17-1871
9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COMM. MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED
11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM S. ANDERSON
14. MOTHER'S MAIDEN NAME: IDA LEISNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: THOMAS H. ANDERSON
Address: 7021 LINDALE DR. BETHESDA MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE. — INTERVAL BETWEEN ONSET AND DEATH: 15 MONTHS
420.0
DUE TO
(b): ATHEROSCLEROTIC HEART DISEASE — 2-3 YRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from MAY, 1956, to AUG 1, 1957, that I last saw the deceased alive on AUGUST 1, 1957, and that death occurred at 6:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. Roberts M.D. ADDRESS (Street, city or town, state): 8907 GEO. AVE. S.S., MD. DATE SIGNED: 8/1/57

PHYSICIAN'S NAME (Type): JAMES A. ROBERTS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-5-57
22c. NAME OF CEMETERY OR CREMATORY: CONGRESSIONAL
22d. LOCATION (City, town, or county) (State): WASHINGTON - D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: 1400 Chapin St.
24a. REC'D BY REGISTRAR DATE: AUG 6 1957
24b. REGISTRAR'S SIGNATURE: Thomas Stellar

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08629 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08609

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seneca
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac River

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Rockville
d. STREET ADDRESS: 402 Blandford St., Apt. 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marvin — Middle: Earl — Last: Atwell
4. DATE OF DEATH: Month: Aug. — Day: 18 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/21/35
9. AGE (In years last birthday): 21 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY: Tree Sergant
11. BIRTHPLACE (State or foreign country): Marion. Va,
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Philip W. Atwell
14. MOTHER'S MAIDEN NAME: Ethel Louise Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Police Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Asphyxia
929.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): drowning
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Drowned while diving in Pot. R., Seneca Md.
20c. TIME OF INJURY: Hour 9 a. m. / p. m. — Month, Day, Year: 8/18/57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Potomac R.
20f. (City or town) (County) (State): Seneca Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-21-57
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak
22d. LOCATION (City, town, or county) (State): Gaithersburg. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ernest C. Gartner.
ADDRESS: Gaithersburg. Md.
24a. REC'D BY REGISTRAR DATE: 8/20/57
24b. REGISTRAR'S SIGNATURE: Laurell Kingsbee

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08630 **CERTIFICATE OF DEATH** 08610

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 119 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Florida
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jacksonville 48X-3
d. STREET ADDRESS: 1619 Perry Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elmer — Middle: Nat — Last: BAILEY

4. DATE OF DEATH: Month: August — Day: 7 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6 May 1901

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy(Retired)

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Charles Edward BAILEY

14. MOTHER'S MAIDEN NAME: ~~XXXXXXXXX~~ Emily DICKERMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-I&II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: (Wife) Vera Burke BAILEY — Address: (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchiogenic Carcinoma left lung
162X
DUE TO
(b): with metastasis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: at least 8 months.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11 April, 1957, to 7 August, 1957, that I last saw the deceased alive on 7 August, 1957, and that death occurred at 1:50P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Larry J. Hines M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-8-57

PHYSICIAN'S NAME (Type): LARRY J. HINES, LCDR,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-9-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: R.A. Pumphrey — ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 8-8-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08631

CERTIFICATE OF DEATH

08611

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 5 WKS.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna
d. STREET ADDRESS: RFD 3 Box 64
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Venia — Middle: Antoinette — Last: Bailey

4. DATE OF DEATH: Month: Aug. — Day: 5 — Year: 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Jan. 24 1868

9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fannin Co. Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Hiram Terry

14. MOTHER'S MAIDEN NAME: Edna Frances Pyle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Address: M.F. Bailey (son) & Hospital records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis — Interval between onset and death: years
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arterio Sclerosis Senility — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-3-, 1957 to 8-5-, 1957, that I last saw the deceased alive on 8-5-, 1957, and that death occurred at 10:18 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): Sandy Spring
DATE SIGNED: 8/5/57

PHYSICIAN'S NAME (Type): J. M. Bird — Sandy Spring, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/8/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington D. C.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Robert A. Pumphrey Bethesda, Maryland

24a. RECEIVED BY REGISTRAR DATE: AUG 6 1957

24b. REGISTRAR'S SIGNATURE: Gertrude Lawlor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08612

.08632

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Dexington Park~~ Vancouver
d STREET ADDRESS: Apt. 204, 878 Clifford ~~Anderson Court~~ St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First David — Middle Mills — Last BANGIT

4. DATE OF DEATH: Month August — Day 6 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 August 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Edward Navaro BANGIT

14 MOTHER'S MAIDEN NAME: Louise Mary MILLS

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT Address: (Father) Edward N. BANGIT (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Pulmonary Atelectasis, postop. — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO (b): Imperforate anus — 33 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 4 August, 19 57, to 6 August, 19 57, that I last saw the deceased alive on 6 August, 19 57, and that death occurred at 7:45A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: LT. [signature] M.D — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-6-57

PHYSICIAN'S NAME (Type): Martin P. Plaut, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-9-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: R.B. Pumphrey — ADDRESS: 7557 Wisconsin Ave., Bethesda, Md

24a. REC'D BY REGISTRAR DATE: 8-6-57

24b. REGISTRAR'S SIGNATURE: Barry E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08633

08613

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 22 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: South Carolina
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Beaufort 77x
d. STREET ADDRESS: 2311 Allison Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Keith; Middle: Evans; Last: BATES

4. DATE OF DEATH: Month: August; Day: 21; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10 February 1938

9. AGE (In years last birthday): 19 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Sidney Walter BATES

14. MOTHER'S MAIDEN NAME: Enid Steedley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (Father) Sidney W. Bates (Same As #2)
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Azotemia
603X
DUE TO (b): Pyelonephritis, Chronic
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Stricture Left ureter and atrophy of Rt. kidney

INTERVAL BETWEEN ONSET AND DEATH: 5 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour o. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 30 July, 1957, to 21 August, 1957, that I last saw the deceased alive on 21 August, 1957, and that death occurred at 9:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert B. Muth, M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md.
DATE SIGNED: 8-22-57

PHYSICIAN'S NAME (Type): Robert B. Muth, LT, MC, USN
U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-27-57
22c. NAME OF CEMETERY OR CREMATORY: National Cemetery
22d. LOCATION (City, town, or county) (State): Beaufort, South Carolina

23. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR
DATE: 8-22-57

24b. REGISTRAR'S SIGNATURE: Mary C. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 48 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Cause: Pending

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08614

Reg. Dist. No. 213

08634

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville R - 2
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): South Glen Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville R - 2
d. STREET ADDRESS: South Glen Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Steven Middle: Roberts Last: Beal

4. DATE OF DEATH: Month: 8/6/57 Day: Year: 19

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/7/1954

9. AGE (In years last birthday): 2 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jeramiah C. Beal

14. MOTHER'S MAIDEN NAME: Beverly Beauchamp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: Father- Address: Item 2.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocarditis due to
DUE TO (b): fulminant infection
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 096.9

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m. Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/7/57

EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/8/57

22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery

22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey Bethesda, Md.

24a. RECD BY REGISTRAR (Date): AUG 9 1957

24b. REGISTRAR'S SIGNATURE: Lowell Traylor LR

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2'57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08635

CERTIFICATE OF DEATH

08615

Reg. Dist. No. 20

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCKVILLE
d. STREET ADDRESS: 618 BLANDFORD ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BABY — Middle MALE — Last BEALL
4. DATE OF DEATH: Month AUG — Day 29 — Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG 29 1957
9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months — Days: 1 — IF UNDER 24 HRS: Hours — Min.: 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HAROLD E BEALL
14. MOTHER'S MAIDEN NAME: FRANCES GRAHAM

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: HAROLD E BEALL — Address: SAME — FATHER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure
DUE TO
(b): Multiple Cardiac Anomalies; TRansposition of
DUE TO
(c): aorta, Pulmonary stenosis, Intraventricular sept. defect, Patent ductus.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 7542

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour — a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/29, 1952 to 8/29, 1957, that I last saw the deceased alive on 8/29, 1957, and that death occurred at 4:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas M. Wilson, M.D. — ADDRESS (Street, city or town, state): 8218 Wise Ave, Berkeley, Md — DATE SIGNED: 8/29/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 9/3/57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Suitland, Md. Prince Geo.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 9-4-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08636

CERTIFICATE OF DEATH

08616

Reg. Dist. No. 214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): rural - Kensington	c. LENGTH OF STAY IN 1b: 18 years
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X rural - Kensington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3400 Nimitz Road	d. STREET ADDRESS: 3400 Nimitz Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First: Laura — Middle: Helen — Last: Beltz	4. DATE OF DEATH: Month: August — Day: 29 — Year: 1957
5. SEX: female	6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: June 6, 1874
9. AGE (In years last birthday): 83 yrs	IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife	10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Pennsylvania	12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: William H. Souders	14. MOTHER'S MAIDEN NAME: Jane Slayman
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs. Vivian Shoemaker, 3400 Nimitz Road	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

420.1

DUE TO (b): Cardio-vascular-renal disease — over 20 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 11, 1942, to August 29, 1957, that I last saw the deceased alive on August 29, 1957, and that death occurred at 7:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Katharine A. Chapman M.D. — ADDRESS (Street, city or town, state): 3924 Baltimore St., Kensington, Md. — DATE SIGNED: Aug. 29, 1957

PHYSICIAN'S NAME (Type): Katharine A. Chapman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 8/31/57	22c. NAME OF CEMETERY OR CREMATORY: Everett Cemetery	22d. LOCATION (City, town, or county) (State): Everett, Bedford, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey	ADDRESS: Bethesda, Maryland	24a. REC'D BY REGISTRAR DATE: 9-4-57	24b. REGISTRAR'S SIGNATURE: Pearle M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08637

CERTIFICATE OF DEATH

08617

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban.

2. USUAL RESIDENCE (Where deceased lived. If institution, res. before admission)
a. STATE: Md. — b. COUNTY: Oakland.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kendale 20.
d. STREET ADDRESS: 425 W. Woodland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Baby — Middle: — Last: Blaurock
4. DATE OF DEATH: Month: Aug — Day: 27 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug 26/57
9. AGE (In years last birthday): yrs — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: 27 — Min.: 38

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not given
14. MOTHER'S MAIDEN NAME: Margaret Anne Blaurock.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mother — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 27 hrs. 38 min
DUE TO
(b): Fetal Atelectasis
DUE TO
(c): Congenital Cerebral Hypoplasia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

753.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a.m. p.m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 26, 1957 to Aug 27, 1957 that I last saw the deceased alive on Aug 27, 1957, and that death occurred at 11:35 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert O. Warthen M.D. — ADDRESS (Street, city or town, state): 3716 Howard Ave., Kens. Md. — DATE SIGNED: 8/27/57

PHYSICIAN'S NAME (Type): Robert O. Warthen — 3716 Howard Ave. Kensington, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/29/57
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 9-4-57
24b. REGISTRAR'S SIGNATURE: Bernice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08638 **CERTIFICATE OF DEATH** Reg. Dist. No. 08618 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 11 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5607 Huntington Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cherry — Middle: B. — Last: Bradley

4. DATE OF DEATH: Month: 8 — Day: 19 — Year: 1957

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/30/07
9. AGE (In years last birthday): 49 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): WISCONSIN
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: JOSEPH BIBA
14. MOTHER'S MAIDEN NAME: EMMA CHESEBRO

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO: NO
17. INFORMANT Address: MR. HERBERT BRADLEY — HUSBAND.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

175X

DUE TO (b): Papillary Carcinoma of Ovary

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Aug 57, 19____, to 19 Aug 57, 19____, that I last saw the deceased alive on 19 Aug 57, 19____, and that death occurred at 12 57 M, from the causes and on the date stated above

ACTUAL SIGNATURE: [signature] M.D.
ADDRESS (Street, city or town, state): 8512 Old Georgetown Rd Bethesda
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/21/57
22c. NAME OF CEMETERY OR CREMATORY: Parklawn Cemetery
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 8-22 57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08639

CERTIFICATE OF DEATH

08619

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 97 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1400 29th St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thomas — Middle: Francis — Last: BREEN

4. DATE OF DEATH: Month: August — Day: 28 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6 January 1897

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician

10b. KIND OF BUSINESS OR INDUSTRY: Commercial

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Patrick BREEN

14. MOTHER'S MAIDEN NAME: Mary A. Mc Namara

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT — Address: (Sister) Mrs. Mae C. Winter (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Portal Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

581.0

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 May, 19 57, to 28 Aug., 19 57, that I last saw the deceased alive on 27 Aug., 19 57, and that death occurred at 7:25A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: C. U. Shilling, M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-28-57

PHYSICIAN'S NAME (Type): C. U. SHILLING, LT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-31-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery

22d LOCATION (City, town, or county) (State): Bladenburg, Rd., Washington, D.C.

23 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Washington, D.C. — Costello Funeral Home, 1722 N. Capitol St.,

24a. REC'D BY REGISTRAR — DATE: 8-28-57

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

I-7 Costello

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08640 Item 2 Fl G219 9-4-57 et

08620 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood RFD # 1
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Russells Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Derwood RFD #1 Silver Spring, Rt. # 2
d. STREET ADDRESS: Olesville-Smithville Rd. Russells Nursing Home
e. IS R. IDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: ; Last: Brooks

4. DATE OF DEATH: Month: 8/10/57; Day: ; Year: 19

5. SEX: male

6. COLOR OR RACE: col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ D VORCED ☐

8. DATE OF B RTH: 4/16/1864

9. AGE (In years last birthday): 93 yrs

IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOC AL SECURITY NO:

17. INFORMANT Address: Patrick Brooks (son) Silver Spring, Md. R 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: 3hrs

4 50.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteo-sclerosis — 5 rs.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDIT ONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): T. B. Rt. Knee 10 yrs.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. p. m.; Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Frank J. Broschart

DATE SIGNED: 8/10/57

22a. BURIAL, CREMATION, REMOVAL (Specify): 8/14/57

22b. DATE THEREOF: Buried

22c. NAME OF CEMETERY OR CREMATORY: Round Oak,

22d. LOCATION (City, town, or county) (State): Spencerville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Saunders

ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: AUG 14 '57

24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMD. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08621

08641 **CERTIFICATE OF DEATH** Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 9810--Ga. Ave. Silver Spring
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Maple Lane Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: XX.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, DC
d. STREET ADDRESS: 812--Longfellow St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DOMA Middle E. Last BROWNING
4. DATE OF DEATH: Month Aug. Day 2nd Year 1957

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Female	White		Jan. 20, 1878	79 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oxon Hill, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred B. Baden
14. MOTHER'S MAIDEN NAME: Harriet Dorcey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Clara E. Harding — Address: 8312--Carey Lane, Silver Springs, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Left Cerebral Hemorrhage	2 wks
DUE TO (b)	Hypertensive Heart Disease	10 yrs.
DUE TO (c)	Diabetes Mellitus	15 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerosis 15 yrs

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 6, 1942, to August 2, 1957, that I last saw the deceased alive on August 2, 1957, and that death occurred at 2:44 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Emmett Laughlin M.D. ADDRESS (Street, city or town, state): 934 Ellsworth Dr Silver Spring DATE SIGNED: 8-2-57
PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county)	(State)
Burial	Aug. 6-57	Arlington National	Arlington	Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros — ADDRESS: 1661--Good Hope Rd., S.E. Washington, DC
24a. REC'D BY REGISTRAR DATE: AUG 5 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08622

08642 **CERTIFICATE OF DEATH**

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 4836 N. 30th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Henry — Middle: Varnum — Last: BUTLER, IV

4. DATE OF DEATH: Month: August — Day: 6 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9 March 1874

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy (Retired)

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Henry V. BUTLER, III

14. MOTHER'S MAIDEN NAME: Mary BRADLEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes 9-5-1891 to 4-1-38

16. SOCIAL SECURITY NO: 225-50-9061

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombosis of Cerebral Vessels due to Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 1 August 1957

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial Pneumonia, Hypostatic Right Lower Lobe 2 August 1957

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 August, 19 57, to 6 August, 19 57, that I last saw the deceased alive on 5 August 1957, and that death occurred at 2:00A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Thirl Jarrett M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-7-57

PHYSICIAN'S NAME (Type): THIRL JARRETT, CAPT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9 Aug. 1957

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph Hawkins Sons — ADDRESS: Gawler's & Sons, 1756 Penn. Ave., N.W. Washington, D.C.

24a. REC'D BY REGISTRAR — DATE: 8-6-57

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director. page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08692

CERTIFICATE OF DEATH

08623

Reg. Dist. No. 7-13

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Oak Haven Rest Home

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: ~~7203~~ 7203 Holly Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First GRACE Middle Lost Byrn

4. DATE OF DEATH: Month August Day 2, Year 1957

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 5/18/1873
9. AGE (In years last birthday) 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Patent Office
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Washington Hakesley
14. MOTHER'S MAIDEN NAME: Mary E. Bandel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: no
17. INFORMANT: Mrs. Harriett Stirling — Address: 7203 Holly Ave. Takoma Park, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Pulmonary Embolism	Immediate
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive Heart Failure	Como
DUE TO (c)	Hypertensive Heart Disease	Long

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

4143X

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m., 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 6 19 57 to Aug 1 19 57 that I last saw the deceased alive on Aug 1 19 57, and that death occurred at 1:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John V Dolan M D — ADDRESS (Street, city or town, state): 3100 Conn Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): John V. Dolan — 3100 Conn. Ave., N.W., Wash. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: 8/5/1957
22c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
22d LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The S. H. Hines Co. 2901 14th St., N.W. Wash DC
24a. REC'D BY REGISTRAR DATE: AUG 6 19
24b. REGISTRAR'S SIGNATURE: J. Wilson Sadler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled ... the funeral director. page 3 ... should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 ... 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

08643 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08624

Item 3: phone call 9-4-57 from informant. L

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE: Md. b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS: 16813 Nelson Lane — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First FRANK Middle LYNN Last CARTER Sr	4. DATE OF DEATH: Month Aug. Day 17 Year 1957
5. SEX: male — 6. COLOR OR RACE: White — 7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: May 10 1879 — 9. AGE (In years last birthday): 78 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired — 10b. KIND OF BUSINESS OR INDUSTRY: Club Mgr. — 11. BIRTHPLACE (State or foreign country): D C	12. CITIZEN OF WHAT COUNTRY: U.S.
13. FATHER'S NAME: Walter Frank Carter	14. MOTHER'S MAIDEN NAME: Arabella Hadley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO.	17. INFORMANT: Frank L. Carter Jr. — Address: 6813 Nelson Lane Bethesda

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

416X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Rheumatic Cardiovascular Disease — years

DUE TO (c): Rheumatic fever — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-1-, 1952, to 8-17, 1957, that I last saw the deceased alive on 8-17, 1957, and that death occurred at 1:55 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Russell M. Tilley, Jr. M.D. — ADDRESS (Street, city or town, state): 4201 Mass Ave NW — DATE SIGNED: 8-17-57

PHYSICIAN'S NAME (Type): Russell M. Tilley — Washington 16 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 8/19/57	22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cem.	22d. LOCATION (City, town, or county) (State): Wash. D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE: Cherry Chevy Funeral Home	ADDRESS: 5103 Wis. Ave. N.W.	24a. REC'D BY REGISTRAR DATE: 8-26-57	24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08644

CERTIFICATE OF DEATH

08625

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 5 H ours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co, General Hosp,

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland — b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Woodbine
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: C OMUS — Middle: — Last: CHR OBOT

4. DATE OF DEATH: Month: August — Day: 21 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb, I7 I889

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawernce Chrobot

14. MOTHER'S MAIDEN NAME: Katie Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): Yes — If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Elsie V. Chrobot — Address: Woodbine, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gastric Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Peptic ulcer. — 6 months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 2 -, 1951 to AUGUST 21, 1957, that I last saw the deceased alive on AUGUST 21, 1957, and that death occurred at 8:50 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. — ADDRESS (Street, city or town, state): Damascus — DATE: 8/21/57

PHYSICIAN'S NAME (Type): JAMES P. KERR M.D. — DAMASCUS, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 24

22c. NAME OF CEMETERY OR CREMATORY: Jennings Chapel

22d. LOCATION (City, town, or county) (State): Jennings Chapel, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W Barber — ADDRESS: Laytonsville. Md.

24a. REC'D BY REGISTRAR DATE: 8-23-57

24b. REGISTRAR'S SIGNATURE: Gertrude B Fawley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08626

08645

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Madisonville
d. STREET ADDRESS: 156 North Seminary Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Omer — Middle: Daniel — Last: Clayton

4. DATE OF DEATH: Month: August — Day: 18 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 27, 1931

9. AGE (In years last birthday): 25 yrs
IF UNDER 1 YEAR: Months: 9 Days: 21
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Coal Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Omer T. Clayton

14. MOTHER'S MAIDEN NAME: Bonnie Bowles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO: Not available

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): INCREASED INTRACRANIAL PRESSURE — INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) METASTATIC MALIGNANT MELANOMA — 2 YEARS

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 30, 19 57, to August 18, 19 57, that I last saw the deceased alive on August 18, 19 57, and that death occurred at 2:30a M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard K. Shaw M.D. — ADDRESS (Street, city or town, state): The Clinical Center — DATE SIGNED: 8/18/57

PHYSICIAN'S NAME (Type): Richard K. Shaw, M. D. — National Institutes of Health, Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-transit

22b. DATE THEREOF: 8/19/1957

22c. NAME OF CEMETERY OR CREMATORY: Browders Cem.

22d LOCATION (City, town, or county) (State): Hopkins Co. Kentucky

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md

24a REC'D BY REGISTRAR DATE: 8-22-57

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, [redacted] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 and the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

08646

CERTIFICATE OF DEATH

08627
216
Reg. Dist. No.

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 17 days
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Alexandria
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d STREET ADDRESS: 303 Hamilton Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wayne — Middle: Allen — Last: Clift

4. DATE OF DEATH: Month: August — Day: 21, — Year: 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: December 9, 1954
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months | Days | Hours | Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b KIND OF BUSINESS OR INDUSTRY: None
11 BIRTHPLACE (State or foreign country): District of Columbia
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Cline A. Clift
14 MOTHER'S MAIDEN NAME: Eroll Hutchins

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO.: None
17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO
(b): Patent Ductus arteriosus. — INTERVAL BETWEEN ONSET AND DEATH: Congenital
DUE TO
(c):

1541

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 4, 1957, to August 21, 1957, that I last saw the deceased alive on August 21, 1957, and that death occurred at 4:40p M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. McFarland M.D.
ADDRESS (Street, city or town, state): The Clinical Center
DATE SIGNED: 8/21/57
PHYSICIAN'S NAME (Type): James A. McFarland, M. D.
National Institutes of Health
Bethesda 14, Maryland

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 26-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat. Cemetery
22d. LOCATION (City, town, or county) (State): Ft Myer, Va.

23 FUNERAL DIRECTOR'S SIGNATURE: H. H. Demaine Jr.
ADDRESS: Alex, Va.
24a DATE RECEIVED BY REGISTRAR: AUG 26 1957
24b REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be directed to page 3 so that it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08647 **CERTIFICATE OF DEATH** Reg. Dist. No. 08628 2 76

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
c. LENGTH OF STAY IN 1b: 34 YRS.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase
d. STREET ADDRESS: 2726 - Washington Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jenny — Middle: R. — Last: Cohen
4. DATE OF DEATH: Month: August — Day: 3 — Year: 1957
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: April 19, 1869
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min: —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Latvia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Nathan Dennison
14. MOTHER'S MAIDEN NAME: Rhoda Salgaller
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Harry H. Cohen — Address: Son; 2726 - Wash. Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cardiac Standstill	5 min
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Arteriosclerotic heart disease	20 years
DUE TO (c)	generalized Arteriosclerosis	20 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of Bladder
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1952, to August 3, 1957, that I last saw the deceased alive on August 3, 1957, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Milton Gusack M.D. — ADDRESS (Street, city or town, state): 1302 - 18th St., N.W. Wash. — DATE SIGNED: 8/3/57

PHYSICIAN'S NAME (Type): Milton Gusack M.D. D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/4/57
22c. NAME OF CEMETERY OR CREMATORY: Wash. Hebrew Congregation
22d. LOCATION (City, town, or county) (State): D.C.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Goldenberg Funeral Home 4217-9th NW
24a. REC'D BY REGISTRAR DATE: 8-5-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08693

CERTIFICATE OF DEATH

08629

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sonv Hosp

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 2214 Prichard Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Catherine; Middle: Ann; Last: Coleman

4. DATE OF DEATH: Month: AUGUST; Day: 23; Year: 19 57

5. SEX: Fe

6. COLOR OR RACE: Cauc

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (Separated)

8. DATE OF BIRTH: 10/8/1905

9. AGE (In years last birthday): 51 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Typist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): DC

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Gorman

14 MOTHER'S MAIDEN NAME: Caroline Ganz

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 578-32-4539

17. INFORMANT: Mrs. Leonard E. Johnson, Address: 2214 Prichard Rd. Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — HEMORRHAGE — DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYPERTENSIVE CARDIO VASCULAR DISEASE — DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. —— 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-23 19 57 to 8-23 19 57, that I last saw the deceased alive on 8/23 19 57, and that death occurred at 11:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Henry W. Stout M.D. ADDRESS (Street, city or town, state): 10611 GEORGIA AVE. SILVER SPRING, MARYLAND DATE SIGNED: 8-23-57

PHYSICIAN'S NAME (Type): HENRY W. STOUT M.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 8/26/57

22c NAME OF CEMETERY OR CREMATORY: St. John's Cemetery

22d LOCATION (City, town, or county) (State): Montgomery County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harned E Pumphrey ADDRESS: 8454 Ga Ave Silver Spring

24a. RECD. BY REGISTRAR DATE: 8/26/57

24b REGISTRAR'S SIGNATURE: Jett Van Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08643

CERTIFICATE OF DEATH

Reg. Dist. No. 08630 2/16

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 hour 25 Min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Forest Heights
d. STREET ADDRESS: 137 Choctaw
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Marie — Middle: Ann — Last: Collier

4. DATE OF DEATH: Month: August — Day: 27 — Year: 1957

5 SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 7 May 1924
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Statistician
10b. KIND OF BUSINESS OR INDUSTRY: Government
11 BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles F. Kidwell
14. MOTHER'S MAIDEN NAME: Sarah Cornell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 579-22-2660
17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

41 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Rheumatic heart disease with mitral and tricuspid stenosis; post-mitral commissurotomy
DUE TO (c): 1956.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 27 August, 19 57, to 27 August, 19 57, that I last saw the deceased alive on 27 August, 19 57, and that death occurred at 10:00 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. McFarland MD
ADDRESS (Street, city or town, state): The National Institutes of Health, The Clinical Center, Bethesda 14, Maryland
DATE SIGNED: 8/27/57
PHYSICIAN'S NAME (Type): James A. McFarland, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 30, 57
22c. NAME OF CEMETERY OR CREMATORY: Arlington, Natl.
22d LOCATION (City, town or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W. W. Chambers Co. 517-11th St. S.E.
24a. REC'D BY REGISTRAR DATE: AUG 29 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08631

08643

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda,
c. LENGTH OF STAY IN 1b: 29 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 4301 Glenrose
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leonard Middle: Manning Last: Colpitts

4. DATE OF DEATH: Month: AUG. Day: 17, Year: 1957

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 25, 1866

9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - RETIRED.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Canada Elgin Albert Co. N.B.

12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME: David Harris

14. MOTHER'S MAIDEN NAME: Frances Mollins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Ida M Cleveland — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Squamous Carcinoma of Urinary Bladder — INTERVAL BETWEEN ONSET AND DEATH: 5yrs+

DUE TO (b): with terminal uremia

DUE TO (c): and pyelonephritis — 3 days.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED White at work ☐ Negro at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from [illegible], 1953, to Aug 17, 1957, that I last saw the deceased alive on Aug 17, 1957, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stewart Clapp M.D.
ADDRESS (Street, city or town, state): 3921 Engonan St NW
DATE SIGNED: Aug 17 57

PHYSICIAN'S NAME (Type): Stewart Clapp
Wash 15 DC

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit
22b. DATE THEREOF: 8-18-57
22c. NAME OF CEMETERY OR CREMATORY: Shirley Village Cem.
22d. LOCATION (City, town, or county) (State): Middlesex Co., Mass.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Dunphey
ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 8-22-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08650 **CERTIFICATE OF DEATH** 08632

Reg. Dist. No.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 10 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 9500 Seminole Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9500 Seminole Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edgington Middle FRANKLIN Last Combes
4. DATE OF DEATH: Month August Day 29 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 17, ~~1857~~ 1901
9. AGE (If years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): General Agent
10b. KIND OF BUSINESS OR INDUSTRY: Brokerage
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Perrea M. Combes
14. MOTHER'S MAIDEN NAME: Dora Franklin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT — Address: Gertrude H. Combes 9500 Seminole Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral anoxia	15 min
DUE TO (b)	Cerebral Thrombosis	30 min
DUE TO (c)	Cerebral Arteriosclerosis	Indefinite

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 7, 1956, to 8/29/57, that I last saw the deceased alive on 8/29/57, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen M. Jones M.D. — ADDRESS (Street, city or town, state): Rockville, Md. — DATE SIGNED: 8/29/57

PHYSICIAN'S NAME (Type): Stephen M. Jones, M.D. — 809 Viers Mill Rd. Rockville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/31/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Prince George County

23. FUNERAL DIRECTOR'S SIGNATURE: Werner C. Humphreys — ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR — DATE: 8-31-57
24b. REGISTRAR'S SIGNATURE: Frances Tittle

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 219 8-16-57 ams

08651

08633

CERTIFICATE OF DEATH

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Rhode Island
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newport
d. STREET ADDRESS: 56 Levin Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Edward — Last: COX

4. DATE OF DEATH: Month: August — Day: 2 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 August 1908

9. AGE (In years last birthday): 48 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy (Retired)

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William COX

14. MOTHER'S MAIDEN NAME: Lydia CHADWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes
(If yes, give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Official Navy Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

151 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinomatosis — 6 mo.

DUE TO (c): Gastric Carcinoma (Adenocarcinoma of Stomach)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 25 July 1957 to 2 August 1957 that I last saw the deceased alive on 1 August 1957, and that death occurred at 7:05A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Douglas R. Koth M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-2-57

PHYSICIAN'S NAME (Type): Douglas R. Koth, LT,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-6-57

22c. NAME OF CEMETERY OR CREMATORY: Island Cemetery

22d. LOCATION (City, town, or county) (State): Newport, Rhode Island

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R.A.Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 8-2-57

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08652 **CERTIFICATE OF DEATH**

08634
Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 7 mos.12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 4, D. C.
d. STREET ADDRESS: 2500 Wisconsin Ave., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Conrad — Middle: Winfield — Last: CRAVEN

4. DATE OF DEATH: Month: August — Day: 14 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3 October 1909

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Wesley CRAVEN

14. MOTHER'S MAIDEN NAME: Ina TRUSTY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes Currently

16. SOCIAL SECURITY NO: 576-10-7337

17. INFORMANT — Address: (Wife) Mrs. Darleen F. CRAVEN (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma, right lung & gastric — INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO (b): metastasis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2 Jan., 1957, to 14 August, 1957, that I last saw the deceased alive on 14 August, 1957, and that death occurred at 3:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-15-57

PHYSICIAN'S NAME (Type): D.P. OSBORNE, CAPT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-16-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.

24a REC'D BY REGISTRAR DATE: 8-15-57

24b REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director. page 3 [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08604 **CERTIFICATE OF DEATH** Reg. Dist. No. 08635

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2301 Conn ave N.W
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Henry — Middle Harland — Last Crowell
4. DATE OF DEATH: Month 8 — Day 3 — Year 1957
5. SEX: M
6. COLOR OR RACE: Cauc
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/29/85
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elisha Crowell
14. MOTHER'S MAIDEN NAME: Ellen Harland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)	Coronary Occlusion	Terminal
420.1 DUE TO (b)	Myocardial Infarction	9 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)	Generalized Arteriosclerosis	?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-27-, 1957, to 8-3-, 1957, that I last saw the deceased alive on 8-3-, 1957, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Hare M.D. — ADDRESS (Street, city or town, state): Takoma Park, Md. — DATE SIGNED: 8/4/57

PHYSICIAN'S NAME (Type): Robert A. HARE

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 7, 1957
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county): Washington, (State) D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The S. H. Hines Company Washington, D. C.
24a. REC'D BY REGISTRAR — DATE: Aug 6 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodds

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 [redacted]d be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [redacted]2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08653

CERTIFICATE OF DEATH

08636

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney	c. LENGTH OF STAY IN 1b: 28 hr. 15 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brinklow	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co. General Hospital, Inc.		d. STREET ADDRESS: 1	e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
John	Edward	Cuff	August	12	19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		7/1/85	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman, District Water	Department	Maryland	United States

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Cuff	Elizabeth Hewitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	579-18-1801	Alice M. Cuff	Brinklow, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

446X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Nephrosclerosis — 6 months

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebrovascular accident 3 mos, — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a. m. p. m.	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			

21. I certify that I attended the deceased from April, 1957, to Aug 12, 1957, that I last saw the deceased alive on Aug 12, 1957, and that death occurred at 3:40 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker, M.D. — ADDRESS (Street, city or town, state): Clarksville, Md. — DATE SIGNED:

PHYSICIAN'S NAME (Type): C. S. Whitaker, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Aug. 15, 1957	Woodside Cemetery	Brinklow, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Conway W. Barber	Laytonsville, Md.	8-15-57	Gertrude B. Fowler

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08654 08637

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown
c. LENGTH OF STAY IN 1b 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 28 - R.F.D. # 2

2. USUAL RESIDENCE (Where deceased lived. If inst'l'n: Residence before admission)
a. STATE Maryland b. COUNTY Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown
d. STREET ADDRESS Route 28 - R.F.D. # 2
e. IS PLACE ON FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Jeffrey Middle: Donohue Last: Cunningham

4. DATE OF DEATH Month: 8 Day: 11 Year: 57 19

5. SEX male

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 7/8/57

9. AGE In years last birthday yrs
IF UNDER 1 YEAR: Months 1 Days 3
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country) md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Tinsley Cunningham

14. MOTHER'S MAIDEN NAME Barbara Jean Baldridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO None

17. INFORMANT Father Address Hwy 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Edema of Larynx
DUE TO (b) Upper Respiratory Infection
DUE TO (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

475X

INTERVAL BETWEEN ONSET AND DEATH: Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M D

EXAMINER'S NAME (Type) FRANK J. BROSCHART

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 8-11-57

22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit

22b. DATE THEREOF 8/12/57

22c. NAME OF CEMETERY OR CREMATORY Hillcrest

22d. LOCATION (City, town, or county) (State) West Palm Beach, Florida

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Md.

24a. REC'D BY REGISTRAR DATE AUG 21 1957

24b. REGISTRAR'S SIGNATURE Alberta Corkey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08605

CERTIFICATE OF DEATH

08638

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 hrs. 6 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanit. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1607 Neeley Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First — Middle — Last: Davey
4. DATE OF DEATH: Month: aug. Day: 28 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: aug 27 - 57
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR IF UNDER 24 HRS: Months — Days — Hours: 30 — Min.: 6

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ralph Phillip Davey
14 MOTHER'S MAIDEN NAME: Shirley Margaret Kelley

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Father — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity
776 X
DUE TO:
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Incomplete Expansion of lungs/
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 27, 1957, to Aug. 28, 1957, that I last saw the deceased alive on Aug. 28, 1957, and that death occurred at 6:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bennet A. Porter Jr. M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED

PHYSICIAN'S NAME (Type): Bennet A. Porter, Jr., M. D. — 9301 Colesville Rd. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8-30-57
22c. NAME OF CEMETERY OR CREMATORY: Washington Sanitarium and Hosp;
22d LOCATION (City, town, or county) (State): Takoma Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Hare, M.D. — ADDRESS: Wash. San. & Hosp.
24a. REC'D BY REGISTRAR DATE: 8/31/57
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

175333 XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08655

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08639

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1½ yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5204 Flanders Ave

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 5204 Flanders Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Simeon — Last: Dayton

4. DATE OF DEATH: Month: 8 — Day: 11 — Year: 57 19

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-27-04

9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traing Mgr

10b. KIND OF BUSINESS OR INDUSTRY: N.I.H.

11. BIRTHPLACE (State or foreign country): N.J.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles F. Dayton

14. MOTHER'S MAIDEN NAME: Flora Wallace

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): WW11
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Ruth Dayton (wife) Address: #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. BROSCHART
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-11-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/14/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a. RECEIVED BY REGISTRAR DATE: 8-14-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08656

CERTIFICATE OF DEATH

08640/15

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 25 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Annapolis
d. STREET ADDRESS: 235 Fig Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Linda — Middle: Jean — Last: DEAR

4 DATE OF DEATH: Month: August — Day: 18 — Year: 1957

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 5 January 1955

9 AGE (In years last birthday): 2 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.

13 FATHER'S NAME: Russell DEAR

14 MOTHER'S MAIDEN NAME: June Edith PERT

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: (Father) Russell Dear, (Same As #2) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 180X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): EMBRYOMA, MALIGNANT OF KIDNEY WITH METASTASES

INTERVAL BETWEEN ONSET AND DEATH: 8½ MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I **certify** that I attended the deceased from 24 July, 1957, to 18 Aug., 1957, that I last saw the deceased alive on 18 August, 1957, and that death occurred at 9:19A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Russell Miller Jr. MD — M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-19-57

PHYSICIAN'S NAME (Type): Russell Miller, Jr. LT,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-21-57

22c. NAME OF CEMETERY OR CREMATORY: Mount Hope Cemetery

22d LOCATION (City, town, or county) (State): New York, New York

23 FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md

24a. REC'D BY REGISTRAR DATE: 8-19-57

24b. REGISTRAR'S SIGNATURE: Mary E. Donnelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08657

CERTIFICATE OF DEATH

08641
Reg. Dist. No. 274

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 8218 Tahona Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8218 Tahona Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First E — Middle HEWITT — Last DIMMITT
4. DATE OF DEATH: Month 8 — Day 31 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/16/1908
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Architect- Draftsman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Birmingham, Alabama
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roy Dimmitt
14. MOTHER'S MAIDEN NAME: Esther H. ----

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service: yes ; W.W.II
16. SOCIAL SECURITY NO.: 215-26-2439
17. INFORMANT: Mrs. Kathryne Dimmitt — Address 8218 Tahona Dr. Silver Spring Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
4 16 X
DUE TO (b): Chronic Heart Disease — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that I attended the deceased from July 19 52 to Aug 31 19 57, that I last saw the deceased alive on Aug 17 19 57, and that death occurred at 5 20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Boris Rabkin M.D. — ADDRESS (Street, city or town, state): 1019 University Boulevard — DATE SIGNED: 8/31/57

PHYSICIAN'S NAME (Type): Boris Rabkin — 1019 University Blvd., East-S.S.Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/3/1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: The S.H.Hines Co.-2901 14th St., N.W. Wash. D.C.
24a. RECD BY REGISTRAR DATE: SEP 3 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

08658

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08642

Reg. Dist. No. 21

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 6 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12226 Center Hill st.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Monty
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12226 Center Hill st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Stella — Middle: Mooney — Last: Dunlop

4. DATE OF DEATH: Month: Aug — Day: 18 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-14-1885

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Pa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Mooney

14. MOTHER'S MAIDEN NAME: Sarah Ward

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Dorothy E. Dunlop — Address: Star Rt 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — Interval between onset and death: sudden
DUE TO
(b): Hypertension — 10 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): FRANK J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8-19-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/21/57
22c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
22d. LOCATION (City, town, or county) (State): Forest Glen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Pumphrey
ADDRESS: Silver Spring

24a. REC'D BY REGISTRAR — DATE: 8/26/57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08659 Item 7 Film 219 8-30-57 et 08643

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Etchison
c. LENGTH OF STAY IN 1b: 50 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R F D 2 Gaithersburg, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Etchison
d. STREET ADDRESS: R F D 2 Gaithersburg
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First NETTIE Middle HAMMOND Last DUVALL

4. DATE OF DEATH: August Day 19 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ married
8. DATE OF BIRTH: Oct. 20
9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Osborn Etchison
14. MOTHER'S MAIDEN NAME: Mary Virginia Penn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): ###
(If yes, give war or dates of service): ###
16. SOCIAL SECURITY NO.: ######
17. INFORMANT: Ollie B. Duvall — Address: Same As 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
420.1
DUE TO (b): Arteriosclerotic cardiovascular lesion — 10 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 2, 19 52 to August 19, 1957, that I last saw the deceased alive on August 18, 1957, and that death occurred at 2 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James P. Kerr M.D. ADDRESS (Street, city or town, state): Damascus, Md. DATE SIGNED: 8/24/57

PHYSICIAN'S NAME (Type): JAMES P. KERR M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug, 21 57
22c. NAME OF CEMETERY OR CREMATORY: Damascus Cemt.
22d. LOCATION (City, town, or county): Damascus (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md.
24a. REC'D BY REGISTRAR DATE: Aug 22/57
24b REGISTRAR'S SIGNATURE: Della N. Burdette

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08606 **CERTIFICATE OF DEATH** Reg. Dist. No. 08644 773

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK
c. LENGTH OF STAY IN 1b LIFE
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
d. STREET ADDRESS 4900 Tuckerman St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Baby Middle Samuel Quint Last Edwards
4. DATE OF DEATH Month August Day 24 Year 19 57

5. SEX male
6. COLOR OR RACE white
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8/24/57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months Days 3 IF UNDER 24 HRS.: Hours 10 Min. 36

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - Infant
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel Irwin Edwards
14. MOTHER'S MAIDEN NAME Dorothy Alice Dunn

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO None
17. INFORMANT Address Samuel E. Edwards - 4900 Tuckerman St Riverdale Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure
DUE TO
762.5
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c) Prematurity
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 24 19 57 to Aug 29 19 57 that I last saw the deceased alive on Aug 29 19 57, and that death occurred at 4:47 p.m., from the causes and on the date stated above.
ACTUAL SIGNATURE Ruth Standard M.D. ADDRESS (Street, city or town, state) Wash. Sant. Hosp. - Aug 30 1957 DATE SIGNED
PHYSICIAN'S NAME (Type) Ruth Standard M.D. Takoma Park Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/31/57
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery
22d. LOCATION (City, town, or county) Colmar Manor Prince Geo Co. (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE Wm. Chambers Co - ADDRESS Riverdale, Md.
24a. REC'D BY REGISTRAR DATE SEP 5 1957
24b REGISTRAR'S SIGNATURE J. Nelson Little

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

2075411XV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08607 **CERTIFICATE OF DEATH** 08645

Reg. Dist. No. 7/13

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia. — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 7216 - 7th St N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Grayce Middle Loreena Last Epperson

4. DATE OF DEATH: Month August Day 2 Year 1957

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Jan 4 1889

9. AGE (In years last birthday): 68 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John M. Elsea

14. MOTHER'S MAIDEN NAME: Margaret L. Miles

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Wash. San. & Hosp. Records. — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 153X Adenocarcinoma, colon, grade 3 — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs
DUE TO (b): Metastasis liver, 1 yr
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19__, to Aug 2, 1957, that I last saw the deceased alive on Aug 2, 1957, and that death occurred at 2.30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 500 N. Underwood St. Washington, D. C. — DATE SIGNED:

PHYSICIAN'S NAME (Type): Chas H. Wolfman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/5/57 — 22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery — 22d. LOCATION (City, town, or county) (State): Prince Georges Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: S. E. Hines Co. — ADDRESS: 2901 14th St N.W. Washington, D.C. — 24a. REC'D BY REGISTRAR DATE: AUG 5 1957 — 24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08660

CERTIFICATE OF DEATH

08646

Reg. Dist. No. 217

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
c. LENGTH OF STAY IN 1b: 3 hrs. 2 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carrol
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby; Middle: Boy; Last: Evans

4. DATE OF DEATH: Month: August; Day: 10; Year: 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/10/57

9. AGE (In years last birthday) yrs

IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS: Hours: 3; Min: 2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: United States

13. FATHER'S NAME: Martin Evans

14. MOTHER'S MAIDEN NAME: Hester Livesay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records
Address: Sandy Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

760.0

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 10, 1957, to Aug 10, 1957, that I last saw the deceased alive on Aug 10, 1957, and that death occurred at 3:32 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles S. Whitaker M.D.
ADDRESS (Street, city or town, state): CLARKSVILLE, MD.
DATE SIGNED: 8/10/57

PHYSICIAN'S NAME (Type): Dr. C. S. Whitaker

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-12-57
22c. NAME OF CEMETERY OR CREMATORY: Steele
22d. LOCATION (City, town, or county) (State): Gaithersburg Rt 2, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Ruth A. Haight
ADDRESS: Doylesville, Md.

24a. REC'D BY REGISTRAR DATE: 8-11-57

24b. REGISTRAR'S SIGNATURE: Gertrude Lasley

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08661

CERTIFICATE OF DEATH

08647 223
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 700 Hudson Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8621 Piney Branch Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROSE Middle MARY Last Fenwick

4. DATE OF DEATH: Month August Day 27 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4/15/1899
9. AGE (In years last birthday): 58 yrs
IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Goverment
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Benedict Fenwick
14. MOTHER'S MAIDEN NAME: Katherine Clark

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT Address: Mr. Hanson Fenwick 2018 Quantico Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

175 X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Carcinoma of left breast with metastasis — 4½ years
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 12 Aug., 1955, to 27 Aug., 1957 that I last saw the deceased alive on 19 Aug., 1957, and that death occurred at 2:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Serich T. Kimble M.D. — ADDRESS (Street, city or town, state): 929 Pershing Dr., Silver Spring 27 Aug. — DATE SIGNED

PHYSICIAN'S NAME (Type): Serich T. Kimble — 929 Pershing Dr., Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/29/57
22c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
22d. LOCATION (City, town, or county) (State): Forest Glen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey — ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 9/9/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08608

CERTIFICATE OF DEATH

08648

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington Sanitarium & Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park 17
d. STREET ADDRESS: 6807 Allegheny Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha Middle Rosetta Last Fichter

4. DATE OF DEATH: Month August Day 30 Year 1957

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12/14/84
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Fichter
14. MOTHER'S MAIDEN NAME: Mary Rye

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NINE
17. INFORMANT: Brother-George T. Fichter
Address: 6807 Allegheny Ave. Tk. Pk. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day
260X
DUE TO (b): Diabetic coma — 3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Cellulitis, left forearm — unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 28, 1957, to Aug 30, 1957, that I last saw the deceased alive on Aug 30, 1957, and that death occurred at 5:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Kenneth Nagi M.D.
ADDRESS (Street, city or town, state): 918 University Blvd. East, Silver Spring, Md.
DATE SIGNED
PHYSICIAN'S NAME (Type): KENNETH NAGI

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Sept 3, 1957
22c. NAME OF CEMETERY OR CREMATORY: PROSPECT HILL CEM.
22d. LOCATION (City, town, or county) (State): WASHINGTON D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Arthur Fellers
ADDRESS: 254 Carroll St NW D.C.
24a. REC'D BY REGISTRAR DATE: 9/3/57
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Typed 1 Film G220 9-24-57 et

08662

08649

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OLNEY
c. LENGTH OF STAY IN 1b: 5 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Old Baltimore Road (Private home)

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: D.C.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 4
d. STREET ADDRESS: 802 Eye St. N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle Joseph — Last Flynn

4. DATE OF DEATH: Month August — Day 27 — Year 1957

5 SEX: Male

6. COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 3, 1883

9. AGE (In years last birthday): 73 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Ireland

12 CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Patrick J. FLYNN

14. MOTHER'S MAIDEN NAME: Bridget Gannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: James D. Flynn — Address: Washington 21, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration and Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 4 hours.
DUE TO
(b): Carcinoma of Head of Pancreas — 1-2 yrs.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

157X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 27, 1957, to Aug 27, 1957, that I last saw the deceased alive on Aug 27, 1957, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard A. Yates M.D. ADDRESS (Street, city or town, state): Olney Md DATE SIGNED: 8/27/57

PHYSICIAN'S NAME (Type): Richard A. YATES

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-31-57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet

22d LOCATION (City, town, or county) (State): Wash. D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Timothy Hanlon — ADDRESS: 3831-Ga. Ave. NW

24a. REC'D BY REGISTRAR DATE: AUG 29 1957

24b. REGISTRAR'S SIGNATURE: Gertrude Lawlor

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08650

08663 **CERTIFICATE OF DEATH**

Reg. Dist. No. 2-17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
c. LENGTH OF STAY IN 1b: 12 hrs. 45 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Foreman

4. DATE OF DEATH: Month: August — Day: 17 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/17/57

9. AGE (In years last birthday): yrs
IF UNDER 1 YEAR: Months: Days: — IF UNDER 24 HRS: Hours: 12 — Min.: 41

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Clifton LeRoy Lyles

14. MOTHER'S MAIDEN NAME: Josephine Elizabeth Foreman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ATELECTASIS
DUE TO (b): PREMATURITY
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

'762.5

INTERVAL BETWEEN ONSET AND DEATH: Few hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/17, 19 57 to —, 19 —, that I last saw the deceased alive on 8/17, 19 57, and that death occurred at 9:45 P.M.; from the causes and on the date stated above.

ADDRESS (Street, city or town, state) — DATE SIGNED

ACTUAL SIGNATURE: G F Meadors M.D. Damascus, Maryland 8/18/57

PHYSICIAN'S NAME (Type): Dr. G. F. Meadors M.D. Damascus, Maryland 8/18/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 19, 1957
22c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove
22d. LOCATION (City, town, or county) (State): Purdum, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE: Chas L. Molesworth ADDRESS: Damascus, Md.

24a. REC'D BY REGISTRAR DATE: 8-19-57

24b. REGISTRAR'S SIGNATURE: Gertrude B Fawley

73244XVO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08609

08651 Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park

c. LENGTH OF STAY IN 1b 8 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanit Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring

d. STREET ADDRESS ~~Edelbut~~ Edelblut Dr.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Hilma Middle Victoria Last Friberg

4. DATE OF DEATH Month Aug. Day 26 Year 1957

5. SEX Female

6. COLOR OR RACE white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Sept. 26 - 1882

9. AGE (In years last birthday) 74 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Sweden

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Johan Johannson

14. MOTHER'S MAIDEN NAME ~~XXXXXXXXX~~ Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. none

17. INFORMANT Hospital Records Address [illegible]

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage in retroperitoneal tissue — INTERVAL BETWEEN ONSET AND DEATH ~~[illegible]~~

DUE TO (b) Rupture of arteriosclerotic aneurysm of abdominal aorta — 2 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last ~~DUE TO~~ (c) — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gall stones ~~[illegible]~~ Diverticulosis colon

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-15 1957, to 8-26 1957, that I last saw the deceased alive on 8-25 1957, and that death occurred at 10 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE Kenneth Laughlin M.D. ADDRESS (Street, city or town, state) 934 Ellsworth Dr. DATE SIGNED 8-26-57

PHYSICIAN'S NAME (Type) Kenneth F Laughlin M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 8/29/57

22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY

22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE Warner E Pumphrey ADDRESS SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE 8/28/57

24b. REGISTRAR'S SIGNATURE J. Milton Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 [redacted] after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled the funeral director, page 3 s[redacted]ld be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08664

CERTIFICATE OF DEATH

08652

Reg. Dist. No. 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg x 2
d. STREET ADDRESS: 31 Walker ave 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Gertrude Middle Elizabeth Last Fulks

4. DATE OF DEATH: Month Aug — Day 16 — Year 1957

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan-3-1874
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house-keeping
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Gaithersburg, Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Wesley Walker
14. MOTHER'S MAIDEN NAME: Amanda Catherine Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17. INFORMANT: Zera Gertrude Fulks, Address 31 Walker ave, Gaithersburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Senility — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO: 160X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): diabetes, arteriosclerosis, organic dementia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-23-1953 to Aug-16-1957, that I last saw the deceased alive on Aug-14-1957, and that death occurred at 7:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Miller M.D. ADDRESS (Street, city or town, state): 2-Brooke Ave DATE SIGNED:

PHYSICIAN'S NAME (Type): WILLIAM C. MILLER Gaithersburg, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/19/57
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery
22d. LOCATION (City, town, or county) (State): Gaithersburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: AUG 19 1957
24b. REGISTRAR'S SIGNATURE: Wheeler Cook

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

VS A1S (4)
1SM 9/SS

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08665 08654

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 1 week
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 6751 Fairfax Road Apt. #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Penna
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lancaster
d. STREET ADDRESS: 329 East Clay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JACOB Middle ALLEN Last GEIST

4. DATE OF DEATH: Month August Day 23, Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 22, 1906
9. AGE (In years last birthday): 51 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Manager for Cigar Company
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): New Holland, Penna.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jacob G. Geist
14. MOTHER'S MAIDEN NAME: Elizabeth Fry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Wife, Laura Geist — Address: 329 E. Clay St. Lancaster, Penna.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: Aug. 24, 1957

EXAMINER'S NAME (Type): FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify): Dremation
22b. DATE THEREOF: 8-24-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Prince George Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY
ADDRESS: Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 8-26-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08666 **CERTIFICATE OF DEATH** Reg. Dist. No. 08656 2/7

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 23 hr. 17 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co. General Hospital, Inc

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: Rt. #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Girl — Last: Gibson

4. DATE OF DEATH: Month: August — Day: 6 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 6, 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours: 23 — Min.: 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Ralph Eugene Gibson

14. MOTHER'S MAIDEN NAME: Margaret Ann Bryan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Not (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Ralph Eugene Gibson Rt. #2 Laurel, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral edema & petechiae — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b): Intestinal fetal distress — 1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Prematurity (33 wk)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____ 19____ to Aug 6 19 57, that I last saw the deceased alive on Aug 6 19 57, and that death occurred at 11:20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. ADDRESS (Street, city or town, state): Sandy Spring Md DATE SIGNED: 8/7/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 8/8/57

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cemetery

22d. LOCATION (City, town, or county) (State): Colmar Manor Md

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Randolph ADDRESS: Laurel Md

24a. REC'D BY REGISTRAR DATE: AUG 8 1957

24b. REGISTRAR'S SIGNATURE: Gertrude Lawlor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08667 (08657)

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chevy Chase, Maryland
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4114 Rosemary Street

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Chevy Chase, Maryland
d. STREET ADDRESS: 4114 Rosemary Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: H — Last: Gibson

4. DATE OF DEATH: Month: August — Day: 24 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/8/1913

9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months: 0 — Days: 16
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Magnus Halvansen

14. MOTHER'S MAIDEN NAME: Martha Klinkenberg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Chevy Chase, Md. — Dr. Gilbert Rude-7700 Glendale Rd.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH: 5 Years

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATE

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Frank Broschart

DATE SIGNED: August 24, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

22b. DATE THEREOF: 8/24/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory

22d. LOCATION (City, town, or county) (State): Suitland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey

ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 8-26-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08668 (08658) Reg. Dist. No. 214

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 213 Whitmoor Terrace

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 213 Whitmoor Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marguerite — Middle: — Last: Gilbert

4. DATE OF DEATH: Month: Aug. — Day: 7, — Year: 1957

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3/22/1898

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ken.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Hampson

14. MOTHER'S MAIDEN NAME: "Not Available"

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO:

17. INFORMANT: Mary F. Gilbert (daughter) Address: # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour — a. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/7/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 9/1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county): Arlington (State): Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [illegible]
ADDRESS: 254 Connell St. NW DC

24a. REC'D BY REGISTRAR: AUG 8 1957
24b. REGISTRAR'S SIGNATURE: Frances Talbot

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMO. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08610 **CERTIFICATE OF DEATH** Reg. Dist. No. 08659 773

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 8621 Piney Branch
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edythe Middle Gladys Last Gilrein

4. DATE OF DEATH: Month August Day 19 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 16, 1904
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): New Hampshire
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Henry Mundy
14. MOTHER'S MAIDEN NAME: Sarah Ann Hardy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
(a) IMMEDIATE CAUSE: Metastasis Squamous cell carcinoma of cervix uteri
DUE TO
(b) Terminal cachexia
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 3 yrs. / 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 6 1944, 19____, to August 17, 1957, that I last saw the deceased alive on 8-19-57, 19____, and that death occurred at 10:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Kenneth Laughlin M.D. ADDRESS (Street, city or town, state): 934 Ellsworth Dr. DATE SIGNED: 8-17-57

PHYSICIAN'S NAME (Type): KENNETH LAUGHLIN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/23/57
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d LOCATION (City, town, or county) (State): Worcester, Mass.

23 FUNERAL DIRECTOR'S SIGNATURE: W W Chambers ADDRESS: Wash. D.C.
24a. REC'D BY REGISTRAR DATE: AUG 22 1957
24b. REGISTRAR'S SIGNATURE: J. M. Pearl Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08669 Item 7 08660

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY Montgomery. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown
d. STREET ADDRESS R.F.D. 1
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: Florence Middle: Elizabeth Last: Holliday
4. DATE OF DEATH Month: August Day: 21, Year: 1957
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH August 19, 1957
9. AGE (In years last birthday) 52½ hrs
IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Clarence Earl Holliday
14. MOTHER'S MAIDEN NAME Betty Elizabeth Saunders

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Father Address Germantown. Md. R.F.D. 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL ANOXIA. — INTERVAL BETWEEN ONSET AND DEATH 52½ hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) — 52½ hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 19, 1957 to August 21, 1957 that I last saw the deceased alive on August 20, 1957, and that death occurred at 5:45 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Robert O. Warthen M.D. ADDRESS (Street, city or town, state) 3716 HOWARD AVE. KENSINGTON, MD. DATE SIGNED 8-24-57

PHYSICIAN'S NAME (Type) ROBERT O. WARTHEN

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-23-57
22c. NAME OF CEMETERY OR CREMATORY Forest Oak
22d. LOCATION (City, town, or county) Gaithersburg (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Vincent E. Fortner ADDRESS Gaithersburg Md.
24a. REC'D BY REGISTRAR DATE 8-26-57
24b. REGISTRAR'S SIGNATURE Bernice M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08670 8,9,11: G219 8/20/57

CERTIFICATE OF DEATH

08661 Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda md
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda xc
d. STREET ADDRESS: 8622 Melwood Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: Mary — Last: Goubleman
4. DATE OF DEATH: Month: 8 — Day: 7 — Year: 1957
5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-31-85
9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Companion-Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Paul Minneapolis, Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Joseph Smutney
14. MOTHER'S MAIDEN NAME: Matoush, (First name MARY)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): ND (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 506-38-3495
17. INFORMANT: Dale E. Goubleman-Item# 2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): multiple metastases, Malignant Melanoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO: 190X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/10 19 57 to 8/7 19 57 that I last saw the deceased alive on 8/7 19 57, and that death occurred at 11:45 A.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED 8/7/57
ACTUAL SIGNATURE Seymour Greenbaum, M.D.
PHYSICIAN'S NAME (Type) SEYMOUR GREENBAUM, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 9, 1957
22c. NAME OF CEMETERY OR CREMATORY: Parklawn
22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 8-10-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08662

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 8 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 525 Albany Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 525 Albany Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NATHAN — Middle FRANCIS — Last GRADY

4. DATE OF DEATH: Month August — Day 7 — Year 19 57

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 14, 1881

9. AGE (In years last birthday): 76 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman (retired)

10b. KIND OF BUSINESS OR INDUSTRY: Used Auto Tires

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Grady

14. MOTHER'S MAIDEN NAME: Elizabeth Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mrs. Myrtle Willie Grady, 525 Albany Ave., Address Takoma Park, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO
(b)
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Found dead in bed

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M. D.

EXAMINER'S NAME (Type): Frank J. Broschart, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: August 7, 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/9/57

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey

ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 7/9/57

24b. REGISTRAR'S SIGNATURE: J. Milton Dodd

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

MS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08671 **CERTIFICATE OF DEATH** Reg. Dist. No. 08663 2/6

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 3 MONTHS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 8401 DIXON AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LIDA Middle M Last GRIFFIN

4. DATE OF DEATH: Month AUGUST Day 26 Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: NOV. 28 1876

9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): NEVADA

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: BILLY OHNEAMA

14. MOTHER'S MAIDEN NAME: NELLIE PARKER

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: EVELYN DUDLEY Address: 8401 DIXON AVE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, GENERALIZED — INTERVAL BETWEEN ONSET AND DEATH: UNABLE TO STATE

199.1

DUE TO (b) CA INTRA-ABDOMINAL

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): GENERALIZED ARTERIOSCLEROSIS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NO

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): NONE

20c. TIME OF INJURY, Month, Day, Year, Hour a.m. p.m.: NONE 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE, 1957, to AUGUST 25, 1957, that I last saw the deceased alive on AUGUST 25, 1957, and that death occurred at 12:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Belden R. Reap M.D. ADDRESS (Street, city or town, state): 11502 Grandview Ave. Wheaton Md. DATE SIGNED: 8/26/57

PHYSICIAN'S NAME (Type): BELDEN R. REAP

22a. BURIAL, CREMATION, REMOVAL (Specify): removal

22b. DATE THEREOF: 8/26/57

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county) (State): Westboro, Mass.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901 12th St. N.W. Washington, D.C.

24a. REC'D BY REGISTRAR: AUG 27 1957

24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08664

08672

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a COUNTY: Montgomery — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c LENGTH OF STAY IN: 1 day
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: Virginia — b COUNTY: Arlington
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d STREET ADDRESS: 1724 North Troy Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Charles — Middle: Edmond — Last: Hanna
4. DATE OF DEATH: Month: August — Day: 8, — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 21, 1888
9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanical Engineer
10b KIND OF BUSINESS OR INDUSTRY: Government
11 BIRTHPLACE (State or foreign country): New York
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: John Hanna
14 MOTHER'S MAIDEN NAME: Annie McQuide

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16 SOCIAL SECURITY NO.: 048-01-6008
17 INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pericarditis
DUE TO (b): carcinoma of larynx
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY: Hour: o m. / p m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 8, 1957 to August 8, 1957 that I last saw the deceased alive on August 8, 1957, and that death occurred at 8:25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John F. Potter M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 8/8/57
PHYSICIAN'S NAME (Type): John F. Potter, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b DATE THEREOF: Aug. 10, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d LOCATION (City, town, or county) (State): Suitland, Maryland.

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph Rawlers Sons
ADDRESS: 1756 Pa. Ave. NW, Washington, D. C.
24a. REC'D BY REGISTRAR DATE: 8-13-57
24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) TSM 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08665

08673

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1304 Viers Mill Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Beverly Middle Ann Last Harding
4. DATE OF DEATH: Month AUGUST Day 6 Year 1957

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUGUST 6, 1957
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR: Months 0 Days 0
IF UNDER 24 HRS: Hours 15 Mins. 34

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Infant---
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Russell Nicholas Harding
14. MOTHER'S MAIDEN NAME: Beulah Katherine Thomas
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO: None
17. INFORMANT: Father — Address: same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Fetal Atlectasis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Immaturity
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 15 hours.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 AUG, 1957, to 6 AUG, 1957, that I last saw the deceased alive on 6 AUG, 1957, and that death occurred at 5:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ira W. Pearlman M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 6 AUG 57

PHYSICIAN'S NAME (Type): Ira W. Pearlman, M. D. 4700 Bradley Blvd. Chevy Chase, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/1957
22c. NAME OF CEMETERY OR CREMATORY: Darnestown Presby Ch.
22d. LOCATION (City, town or county) (State): Montg. Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-7557 ADDRESS: Wis. Ave. Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 8-10-57
24b. REGISTRAR'S SIGNATURE: Bernie M. Thompson

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08674

CERTIFICATE OF DEATH

08666

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 1304 Vera Mill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bryon — Middle: Eugene — Last: Harding

4. DATE OF DEATH: Month: Aug — Day: 7 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 6, [illegible]
9. AGE (If years last birthday) yrs.
IF UNDER 1 YEAR: Months: 0 — Days: 2
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Md. U.S.A.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Russell Nicholas Harding
14. MOTHER'S MAIDEN NAME: Beulah Katherine Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Father — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fetal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Immaturity
DUE TO (c): Multiple Birth
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 6, 19 57 to Aug 7, 19 57, that I last saw the deceased alive on Aug 7, 19 57, and that death occurred at 7:50 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ira W. Pearlman M.D.
ADDRESS (Street, city or town, state): 4700 Bradley Blvd, Chevy Chase, Md.
DATE SIGNED: 7 Aug 57

PHYSICIAN'S NAME (Type): Ira W. Pearlman, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/9/1957
22c. NAME OF CEMETERY OR CREMATORY: Darnestown Presby Ch.
22d. LOCATION (City, town, or county) (State): Montg. Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 8-10-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

74-274 X 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08612

CERTIFICATE OF DEATH

08667

Reg. Dist. No. 2-23

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Oakharen Conv. Home.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park.
d. STREET ADDRESS: 1001 Kentland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Martha — Middle Bell — Last Harrington
4. DATE OF DEATH: Month August — Day 17 — Year 1957
5. SEX: female
6. COLOR OR RACE: Caucasion
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 23. 1867
9. AGE (In years last birthday) yrs: 89
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired. HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): LISBON, MAINE
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN HOOGKIN
14. MOTHER'S MAIDEN NAME: ARABEL BUCKMAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: Mrs Edna H. Nugent, Address: Takoma Park, Md. 1001 Kentland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week.
DUE TO (b): Generalized arteriosclerosis — 40 years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 2 1957, to August 17 1957 that I last saw the deceased alive on August 17, 1957, and that death occurred at 6:40 P.M. from the causes and on the date stated above

ACTUAL SIGNATURE: Charles W. Humphreys Jr. M.D. — ADDRESS (Street, city or town, state): 1746 K St. N.W. Washington D.C. — DATE SIGNED: 8/21/57

PHYSICIAN'S NAME (Type): Charles W. Humphreys, Jr.

22a. BURIAL, CREMATION, OR REMOVAL (Specify): BURIAL
22b. DATE THEREOF: Aug 21, 1957
22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN CEMETERY
22d. LOCATION (City, town, or county): PORTLAND (State): MAINE

23. FUNERAL DIRECTOR'S SIGNATURE: [redacted] — ADDRESS: Tak. Pk. D.C. 257 Carroll St. NW.
24a. REC'D BY REGISTRAR DATE: 7/20/57
24b. REGISTRAR'S SIGNATURE: Edna Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08668

Reg. Dist. No. 212

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boyds
c. LENGTH OF STAY IN 1b 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. R-117

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Fla. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gainesville
d. STREET ADDRESS R-4 Box 359
e. DID DECEDENT EVER ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Frank Middle: E Last: Hastings
4. DATE OF DEATH Month: Aug Day: 14 Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 11-27-52
9. AGE (In years last birthday) 4 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Fla.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Peter Hastings
14. MOTHER'S MAIDEN NAME Janet Howard
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Peter Hastings Address Star Rt 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) drowning
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Wondered By alone and fell in pond
20c. TIME OF INJURY Hour 7:30 a.m. p.m. Month, Day, Year 8-14 1957
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm
20f. (City or town) Boyds (County) Monty. (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 8-14-57
EXAMINER'S NAME (Type) FRANK J. BROSCHART

22a. BURIAL, CREMATION, REMOVAL (Specify) Buried
22b. DATE THEREOF Aug 19-57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county) Lakeland (State) Florida

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS William B. Hilton, Barnesville, Md
24a. RECEIVED BY REGISTRAR DATE Aug 16, 57
24b. REGISTRAR'S SIGNATURE Charles W. Elgin M.D.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08669

Item 8 Film 220 9-17-57 ¢

08676

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 11 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 902 LANGLEY DRIVE

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: / 902 LANGLEY DRIVE
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle H. Last HEIGHAM

4. DATE OF DEATH: Month AUGUST Day 2 Year 1957

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1869 NOV. 25, 1867
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister (retired)
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (State or foreign country): ENGLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM J. HEIGHAM
14. MOTHER'S MAIDEN NAME: ANNE HIRST

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: Miss Una Heigham, 902 Langley Dr. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

DUE TO (b): Hypertension — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 443X

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to Aug 2, 1957, that I last saw the deceased alive on Aug 2, 1957, and that death occurred at 2:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John N. Andrews M.D. ADDRESS (Street, city or town, state): 904 Colesville Rd Silver Spring Md DATE SIGNED: Aug 2 57

PHYSICIAN'S NAME (Type): JOHN N. ANDREWS

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/5/57
22c. NAME OF CEMETERY OR CREMATORY: ST. BARNABAS EPISCOPAL CHURCH CEMETERY
22d. LOCATION (City, town, or county) (State): OXEN HILL, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 8/5
24b. REGISTRAR'S SIGNATURE: Spencer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08677 **CERTIFICATE OF DEATH** 08670

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5518 Southwick Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 5518 Southwick Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Matilda — Middle: M. — Last: HENKELMAN

4. DATE OF DEATH: Month: August — Day: 14 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 15, 1870

9. AGE (In years last birthday): 87 yrs — IF UNDER 1 YEAR: Months: 8 Days: 29 — IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: - - - -

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George H. Henkelman

14. MOTHER'S MAIDEN NAME: Anna Elizabeth Stein

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Augusta Henkelman-Same Item #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Disecting aneurysm of the Aorta — INTERVAL BETWEEN ONSET AND DEATH: many

451X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Atherosclerosis of the Aorta — years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paula E. Mahler, M.D. M.D

ADDRESS (Street, city or town, state):

DATE SIGNED:

PHYSICIAN'S NAME (Type): Paula Mahler, M. D. — 5311 Roosevelt Street, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/17/57

22c. NAME OF CEMETERY OR CREMATORY: Parklawn

22d. LOCATION (City, town, or county) (State): Rockville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 8-14-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be [illegible] by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08678

08671

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda, Md.
c. LENGTH OF STAY IN 1b: 1 wk.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: None

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE: Pennsylvania
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clairton, Pa(Rural) R.D.#1 Coal Valley Rd
d. STREET ADDRESS: R.D.#1, Coal Valley Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Lillian; Middle:; Last: Heron

4. DATE OF DEATH: Month: Aug.; Day: 18; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 15, 1902

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewfie

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Willouk, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Holmes

14. MOTHER'S MAIDEN NAME: Sarah A. Fornear, Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Jean Wise, Daughter Address: Above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 26 hrs.

4435

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Cardic-vascular disease — 10 yrs.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-17-57, 19__, to 8-18, 1957, that I last saw the deceased alive on 8-18-57, 19__, and that death occurred at 1:05 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: John B. Umhau M.D. — ADDRESS (Street, city or town, state): 8805 Conn Ave. — DATE SIGNED: 8/18/57

PHYSICIAN'S NAME (Type): John B. Umhau — Chevy Chase 15 Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Transit

22b. DATE THEREOF: 8-19-57

22c. NAME OF CEMETERY OR CREMATORY: Jefferson Meth. Cem.

22d. LOCATION (City, town, or county) (State): R.D. #1, Clairton, Pa.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 8-22-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08679 **CERTIFICATE OF DEATH** 08672

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: MONTGOMERY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

c. LENGTH OF STAY IN 1b: 4 yrs.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 12,004 Colesville Road

d. STREET ADDRESS: 12,004 Colesville Road

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLIFTON Middle DAVID Last HOWELLS

4. DATE OF DEATH: Month AUGUST Day 9 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/20/91

9. AGE (In years last birthday): 65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ordnance worker

10b. KIND OF BUSINESS OR INDUSTRY: Fidelity Storage Co.

11. BIRTHPLACE (State or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Howells

14. MOTHER'S MAIDEN NAME: Anne Thomas

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 577-09-3491

17. INFORMANT Address: Mr. F. W. Davis, 12,004 Colesville Road Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Generalized inanition — INTERVAL BETWEEN ONSET AND DEATH: 7 days

153X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinomatosis generalized — 10 months

DUE TO (c): Carcinoma of colon — 14 months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Oct, 1956, to Aug, 1957, that I last saw the deceased alive on Aug 9, 1957, and that death occurred at 5 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ralph F. Patten M.D. ADDRESS (Street, city or town, state): 8641 Colesville Road Silver Spring, Md DATE SIGNED: Aug 9, 57

PHYSICIAN'S NAME (Type): RALPH F. PATTEN M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/12/57

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

22d. LOCATION (City, town, or county) (State): Prince Geo. County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 8/21/57

24b. REGISTRAR'S SIGNATURE: Frances Patten

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08680 **CERTIFICATE OF DEATH** 08673

Reg. Dist. No. 21

1 PLACE OF DEATH
a COUNTY: MONTGOMERY — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

c LENGTH OF STAY IN 1b: 11 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1221 DALE DRIVE

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE: MARYLAND b. COUNTY: MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING

d. STREET ADDRESS: 1221 DALE DRIVE

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FRANCES Middle LACEY Last HUNTER

4. DATE OF DEATH: Month AUG. Day 18 Year 19 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 9/19/78

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS: Hours | Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOMEMAKER

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM A. CLARKE

14 MOTHER'S MAIDEN NAME: FRANCES T. TRUNNELL

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)

16 SOCIAL SECURITY NO: 214-36-1834

17 INFORMANT: Mrs. Louise H. Hughes, Address 13,500 Grenoble Dr. ~~Rockville, Md.~~

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] B

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Fibrosis — INTERVAL BETWEEN ONSET AND DEATH: 3½ years

525 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 250 X Diabetes mellitus.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from March, 19 57, to August 16, 19 57, that I last saw the deceased alive on August 16, 19 57, and that death occurred at 2:30 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Aaron H. Traum M.D. ADDRESS (Street, city or town, state): 8237 Georgia Ave, Silver Spring, Md. DATE SIGNED: Aug 19 57

PHYSICIAN'S NAME (Type): Aaron H. Traum

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 8/21/57

22c. NAME OF CEMETERY OR CREMATORY: ST. JOHN'S CEMETERY

22d. LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 8/26/57

24b. REGISTRAR'S SIGNATURE: Francis Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 18 Film 220 9-[illegible]

08681

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08674

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
d. STREET ADDRESS: Barracks #112 U.S. Naval Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roland; Middle: Jennings; Last: HURST

4. DATE OF DEATH: Month: August; Day: 22; Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8-26-24
9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy
11. BIRTHPLACE (State or foreign country): Florida
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Solmon Daniel HURST
14. MOTHER'S MAIDEN NAME: Vida (last name unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]: Yes Currently
16. SOCIAL SECURITY NO.: 263 60 3052
17. INFORMANT (Address): Official Navy Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary thrombosis left Ant. descending branch — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

420.1

DUE TO (b): Coronary sclerosis

DUE TO (c): Arteriolar nephrosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic passive congestion of all viscera; Pulmonary edema

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m.; Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 23 Aug. 1957

EXAMINER'S NAME (Type): Frank J. Broschart, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-28-57
22c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
22d. LOCATION (City, town, or county) (State): Tampa, Florida

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 8-23-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08613 **CERTIFICATE OF DEATH** Reg. Dist. No. 08675

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 5 Months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 7111 Bradley Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mattie Middle: Ellen Last: Hutt
4. DATE OF DEATH: Month: August Day: 13 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12-18-78
9. AGE (In years last birthday): 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Stanley Taylor
14. MOTHER'S MAIDEN NAME: Mary C. Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --------
16. SOCIAL SECURITY NO: ----------
17. INFORMANT: Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Terminal
DUE TO (b): Exhaustion — Six months
DUE TO (c): Carcinomatosis of Omentum & Colon — 9 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from March, 1957, to 8-13, 1957, that I last saw the deceased alive on 8-12-, 1957, and that death occurred at 2:55 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A'Hare, M D
ADDRESS (Street, city or town, state): Takoma Park, Md.
DATE SIGNED: 8/13/57
PHYSICIAN'S NAME (Type): Robert A. HARE, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/16/57
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cem.
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Hallen Funeral Home, Inc.
ADDRESS: Mt. Rainier, Md.
24a. REC'D BY REGISTRAR DATE: AUG 19 1957
24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08682

CERTIFICATE OF DEATH

08676

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 [redacted] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and [redacted] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Montgomery — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY:
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda — c. LENGTH OF STAY IN 1b: 7 hrs 45 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): California
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Naval Hosp, NNMC, Bethesda, Md. — d. STREET ADDRESS: Long Apts — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒	

3. NAME OF DECEASED (Type or print)	First: Baby Boy	Middle:	Last: Imholte	4. DATE OF DEATH	Month: August	Day: 11	Year: 1957	
5. SEX: Male	6. COLOR OR RACE: Cauc	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: August 11, 1957	9. AGE (In years last birthday) yrs	IF UNDER 1 YEAR Months:	Days:	IF UNDER 24 HRS Hours: 7	Min.: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None	10b. KIND OF BUSINESS OR INDUSTRY: None	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Gerald J. Imholte	14. MOTHER'S MAIDEN NAME: Luella Tone Johnson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Gerald J. Imholte, Longs Apts, California, Md.	Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Immaturity (abnormal pulmonary ventilation) — INTERVAL BETWEEN ONSET AND DEATH: 7 hours 45 minutes

DUE TO (b): prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that I attended the deceased from 11 Aug, 1957, to 11 Aug, 1957, that I last saw the deceased alive on 11 August, 1957, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Daniel Shupter M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, NNMC, Beth. Md. — DATE SIGNED: 8-11-57

PHYSICIAN'S NAME (Type): LT Daniel Shupter, MC, USN — U.S. Naval Hospital, NNMC, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 13 Aug. 1957	22c. NAME OF CEMETERY OR CREMATORY: St. Anne's Church Cemetery	22d. LOCATION (City, town, or county): Kimball,	(State): Minnesota
23. FUNERAL DIRECTOR'S SIGNATURE: R. [illegible] TEMPLEY	ADDRESS: [illegible] WISCONSIN AVE, BETHESDA, MD	24a. REC'D BY REGISTRAR DATE: 8-11-57	24b. REGISTRAR'S SIGNATURE: Mary E. Connelly	

51 51 XVII

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08683

CERTIFICATE OF DEATH

08677

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 8 hr. 17 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, NNMC, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: ~~Pennsylvania~~
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ~~Yeadon~~, Aquasco 16X-2
d. STREET ADDRESS: ~~x/x Robinwood~~
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: JACKSON

4. DATE OF DEATH: Month: August — Day: 6 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 5 1957

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours: 8 | Min.: 17

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Fussell JACKSON

14. MOTHER'S MAIDEN NAME: Elois WILLS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: None

17. INFORMANT: Official Navy Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Hyaline Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 1/2 hrs

DUE TO (b): Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5 August, 1957, to 6 August, 1957, that I last saw the deceased alive on 6 August 1957, 19____, and that death occurred at 4:40A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. C. Parke M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-7-57

PHYSICIAN'S NAME (Type): J. C. PARKE, JR.LT,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-7-57

22c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery

22d. LOCATION (City, town, or county) (State): Waldorf, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: George Adams — ADDRESS: Huntt & Ryon, Waldorf, Maryland

24a. REC'D BY REGISTRAR DATE: 8-7-57

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08684 08678

CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 47 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 6938 Blaisdell Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Cora — Middle: Emma — Last: Jensen
4. DATE OF DEATH: Month: August — Day: 17 — Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 10, 1895
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: Accounting
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Wilford Phippen
14. MOTHER'S MAIDEN NAME: Emma Williams
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 556-12-0974
17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): HODGKINS DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 3 YEARS
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 1, 1957 to August 17, 1957 that I last saw the deceased alive on August 17, 1957, and that death occurred at 9:45 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard K. Shaw M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 8/18/57
PHYSICIAN'S NAME (Type): Richard K. Shaw, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Transit
22b. DATE THEREOF: 8/20/57
22c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
22d. LOCATION (City, town, or county) (State): Whittier, LA Co. California

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 8-22-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08679

08614

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park, Md
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium + Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: West Cottage, Wash. San. Hosp.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ERNST — Middle (WMN) — Last Joerg
4. DATE OF DEATH: Month August — Day 30 — Year 1957

5. SEX: male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 8/29/75
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maintenance
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Switzerland
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Gottlieb Joerg
14. MOTHER'S MAIDEN NAME: Mary Wassenfallen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO:
17. INFORMANT — Address: medical records.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Occlusion - recurrent acute — Interval between onset and death: Terminal

DUE TO (b): Coronary Occlusion — three wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Arteriosclerosis — years.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-10-, 1957, to 8-30-, 1957, that I last saw the deceased alive on 8-30-, 1957, and that death occurred at 10:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Hare, M.D. — ADDRESS (Street, city or town, state): Takoma Park, Md. — DATE SIGNED: 8/31/57

PHYSICIAN'S NAME (Type): Robert A. HARE.

22a. BURIAL, CREMATION, REMOVAL (Specify): Transit Burial
22b. DATE THEREOF: 9/3/1957
22c. NAME OF CEMETERY OR CREMATORY: Floral Cemetery
22d. LOCATION (City, town, or county) (State): Indianapolis Indiana

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J. Arthur Walters, 254 Carroll St. N.W. D.C.
24a. REC'D BY REGISTRAR DATE: 9/3/57
24b. REGISTRAR'S SIGNATURE: J. Richard Todd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08685 08680

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a STATE VIRGINIA b. COUNTY FAIRFAX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA
d STREET ADDRESS 6908 CHACO ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First TWIN "A" Middle Baby Boy Last Johnson
4. DATE OF DEATH Month August Day 28 Year 1957

5 SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH Aug 27/57
9. AGE (In years last birthday) yrs
IF UNDER 1 YEAR Months Days 1 IF UNDER 24 HRS Hours 15 Min 18

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) MARYLAND
12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME FRANK J. JOHNSON
14. MOTHER'S MAIDEN NAME SARAH GARDNER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO none
17 INFORMANT Address FRANK J. JOHNSON - SAME FATHER

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Maternal Toxemia (Ruptured Appendix)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 27, 1957, to Aug 28, 1957 that I last saw the deceased alive on Aug 28, 1957, and that death occurred at 3 3/4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE R H Mitchell M.D.
ADDRESS (Street, city or town, state) 8218 Wisconsin Ave
DATE SIGNED
PHYSICIAN'S NAME (Type) R H MITCHELL Bethesda Md.

22a BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 9/3/1957
22c NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory
22d LOCATION (City, town, or county) (State) Prince Georges Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.
24a. REC'D BY REGISTRAR DATE 9-4-57
24b REGISTRAR'S SIGNATURE Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2274.25 VV2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08686

CERTIFICATE OF DEATH

08681

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Alexandria
d STREET ADDRESS: 6908 Chaco Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Twin Baby Boy — Middle: "B" — Last: Johnson
4. DATE OF DEATH: Month: Aug — Day: 28 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 27-57
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days — Hours: 5 — Min.: 27 — IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U S A
13 FATHER'S NAME: Frank Jamison Johnson
14. MOTHER'S MAIDEN NAME: Sarah Gardner
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: none
17 INFORMANT — Address: Frank J. Johnson - Same Item #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumatosis — INTERVAL BETWEEN ONSET AND DEATH: 4 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO (c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour: a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 27 Aug, 1957, to 28 Aug, 1957, that I last saw the deceased alive on 28 Aug, 1957, and that death occurred at 4:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: T. H. Mitchell M.D. — ADDRESS (Street, city or town, state): 9216 Wisconsin Ave Bethesda Md — DATE SIGNED: 28 Aug 57

PHYSICIAN'S NAME (Type): T H MITCHELL MD — Bethesda Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 9/3/1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d LOCATION (City, town, or county) (State): Prince Georges Maryland

23 FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: 7557 Wis. Avenue, Bethesda, Md.
24a. REC'D BY REGISTRAR DATE: 9-4-57
24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 [illegible] the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08682

08615

CERTIFICATE OF DEATH

Reg. Dist. No. 7-73

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 39 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San + Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Georgia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lithonia
d. STREET ADDRESS P.O. Box 233
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Grace Middle Elizabeth Last Johnson
4. DATE OF DEATH Month 8 Day 10 Year 1957
5. SEX Fe
6. COLOR OR RACE Wh.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 4-21-96
9. AGE (In years last birthday) 61 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kansas.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Crawford
14. MOTHER'S MAIDEN NAME Hilda ERICSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO yes
17. INFORMANT Husband - Address Same.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 years
DUE TO 153.x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO (c) Carcinoma primary Colon, Splenic Flexure

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 7, 1957 to Aug 12, 1957 that I last saw the deceased alive on Aug 9, 1957, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE John N. Andrews M.D
ADDRESS (Street, city or town, state) 9601 Colesville Rd
DATE SIGNED 8-10-57
PHYSICIAN'S NAME (Type) John N Andrews M.D. Silver Spring Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/13/57
22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or county) (State) Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE AUG 12 1957
24b. REGISTRAR'S SIGNATURE J. Wilson Liddy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08687 08683

CERTIFICATE OF DEATH

Reg. Dist. No 217

1 PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney
c. LENGTH OF STAY IN 1b 2yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood Pk. - Silver Spr.
d. STREET ADDRESS 610 Hollywood Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mae Middle Lost Johnson

4. DATE OF DEATH Month Aug. Day 14 Year 1957

5 SEX F

6. COLOR OR RACE W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH Aug. 28-1874

9. AGE (In years last birthday) 82 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Mont. Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Andrew Jackson Thompson

14. MOTHER'S MAIDEN NAME Mary Elizabeth Harding

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 577-34-7405

17. INFORMANT Address Daughters + Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia, Lemon Injn — INTERVAL BETWEEN ONSET AND DEATH 3 hrs

443X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypostatic cardiac decay — 11 yrs

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1955, to August 14, 1957, that I last saw the deceased alive on Aug. 13, 1957, and that death occurred at 4:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE A. D. Bonifant M.D. ADDRESS (Street, city or town, state) Silver Spring, Md. DATE SIGNED 8/14/57

PHYSICIAN'S NAME (Type) A. D. BONIFANT

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 8/16/57

22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey ADDRESS Silver Spring, Md.

24a REC'D BY REGISTRAR DATE 8-17-57

24b. REGISTRAR'S SIGNATURE Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08688

08684

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri — b. COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda

c. LENGTH OF STAY IN 1b: 95 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kansas City

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS: 114 North Chelsea Averne

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Ruth — Last: Kapprel

4. DATE OF DEATH: Month: August — Day: 13, — Year: 1957

5 SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1918

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: unknown

11 BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: John Rainey

14 MOTHER'S MAIDEN NAME: Nancy Mann

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16 SOCIAL SECURITY NO: unknown

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hepatic Failure - Hepatitis of unknown etiology — INTERVAL BETWEEN ONSET AND DEATH: 10 days

173 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Choriocarcinoma — 8 Months

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 10, 1957 to August 13, 1957, that I last saw the deceased alive on August 13, 1957, and that death occurred at 9:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Charles F. Nadler M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 8/13/57

PHYSICIAN'S NAME (Type): Charles F. Nadler, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b DATE THEREOF: 8/13/57

22c NAME OF CEMETERY OR CREMATORY:

22d LOCATION (City, town, or county) (State): Kansas City, Missouri

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 8-14-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled [illegible] the funeral director should be filed with page 3 [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08685

08689

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 6 ROCKVILLE
d. STREET ADDRESS: CITY 13, NORBECK RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BESSIE — Middle: MAY — Last: KEENE

4. DATE OF DEATH: Month: AUGUST — Day: 7 — Year: 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 12, 1882

9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSELIFE

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN GATES

14. MOTHER'S MAIDEN NAME: NEALY GATES

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: HERMAN C. KEENE CITY 13, NORBECK RD. ROCKVILLE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 4 days

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Arteriosclerotic cardiovascular disease years

~~DUE TO~~ (c): Uremia

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma of cervix

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/2, 1957, to 8/7, 1957, that I last saw the deceased alive on 8/6, 1957, and that death occurred at 12:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen C. Cromwell M.D. — ADDRESS (Street, city or town, state): 615 W. Montgomery Ave, Rockville Md — DATE SIGNED: 8/7/57

PHYSICIAN'S NAME (Type): STEPHEN C CROMWELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-10-57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. W. Chambers Co. 517-11th St. S.E.

24a. REC'D BY REGISTRAR — DATE: AUG 12 1957

24b. REGISTRAR'S SIGNATURE: Beasie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08690 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 08686

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
   a. COUNTY: Montgomery — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4807 Randolph Road, Silver Spring

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring, Maryland
   d. STREET ADDRESS: 4807 Randolph Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Newton — Middle: Amos — Last: Kendall

4. DATE OF DEATH: Month: August — Day: 24 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/22/1883

9. AGE (In years last birthday): 73 yrs.
   IF UNDER 1 YEAR: Months: 8 — Days: 2
   IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: Us

13. FATHER'S NAME: Amos Fenton Kendall

14. MOTHER'S MAIDEN NAME: Martha Gordon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT — Address: Pauline Ertter, same as Item #2d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J Broschart M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/24/57

EXAMINER'S NAME (Type): Frank Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/27/1957

22c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove

22d. LOCATION (City, town, or county) (State): Fairfax Co. Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md

24a. REC'D BY REGISTRAR DATE: 9-4-57

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

08691

CERTIFICATE OF DEATH

08688

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4618 Chestnut Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
d. STREET ADDRESS: 4618 Chestnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olivia — Middle: — Last: KNIGHT

4. DATE OF DEATH: Month: August — Day: 3, — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 17, 1888

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months: 0 Days: 16 — IF UNDER 24 HRS: Hours: — Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Govt. Employee

10b. KIND OF BUSINESS OR INDUSTRY: Govt.

11. BIRTHPLACE (State or foreign country): Big Fork, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Victor L. Knight

14. MOTHER'S MAIDEN NAME: Amelia Knight Larsen

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. M, L, Bixby-Same Item #2 — Cousin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: o. m. p. m — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCTOBER, 1950, to Aug. 3, 1957, that I last saw the deceased alive on Aug. 3, 1957, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul D. Cantor M.D. — ADDRESS (Street, city or town, state): 4709 Montg. Lane, Bethesda, Md. — DATE SIGNED: 8/3/57

PHYSICIAN'S NAME (Type): Paul D. Cantor, M. D. — 4709 Montgomery Lane, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-transit

22b. DATE THEREOF: 8/ 5 /1957

22c. NAME OF CEMETERY OR CREMATORY: Schoolcraft Memorial

22d. LOCATION (City, town, or county) (State): Kalamazoo Co. Michigan

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 8-7-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08616

CERTIFICATE OF DEATH

08689

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington San & Hosp

2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission)
a. STATE Maryland
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Karen Middle Lee Last Kreiger

4. DATE OF DEATH Month 8 Day 9 Year 1957

5. SEX Female
6. COLOR OR RACE Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 8-4-57
9. AGE (In years last birthday) yrs.
IF UNDER 1 YEAR Months Days 5
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard K. Kreiger
14. MOTHER'S MAIDEN NAME Emma Beames de Sav

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT Hospital Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 5 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-4, 1957 to 8-9, 1957 that I last saw the deceased alive on 8-6-57, 19____, and that death occurred at ____M, from the causes and on the date stated above.

ACTUAL SIGNATURE Herbert D Glick M.D.
ADDRESS (Street, city or town, state) Silver Spring, Maryland
DATE SIGNED 8-9-57

PHYSICIAN'S NAME (Type) Herbert D. Glick, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
22b. DATE THEREOF 8-10-57
22c. NAME OF CEMETERY OR CREMATORY Washington San & Hosp
22d. LOCATION (City, town, or county) (State) Takoma Park, Md.

23. FUNERAL DIRECTOR'S SIGNATURE T. S. Tice, M. D.
ADDRESS Wash. San. & Hosp.
24a. REC'D BY REGISTRAR DATE 7/2/57
24b. REGISTRAR'S SIGNATURE J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (II)
1SM 9/[illegible]S

2075332 X VC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08692

CERTIFICATE OF DEATH

08690

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 55 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47x
d. STREET ADDRESS: 1324 29th Street, N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Cascaden — Last: KRINER
4. DATE OF DEATH: Month: August — Day: 12 — Year: 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 25 May 1894
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Navy(Retired)
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Bryon KRINER (579 38 5059)
14. MOTHER'S MAIDEN NAME: Margaret Cascaden

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): 7-06-11 to 3-1-45
16. SOCIAL SECURITY NO: XXXXXXXX
17. INFORMANT — Address: (Wife) Mrs. Isabel W. Kriner (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia, lobular bilateral — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Pulmonary Fibrosis & emphysema, far
DUE TO (c): advanced, chronic — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 19 June, 1957, to 12 August, 1957, that I last saw the deceased alive on 12 August, 19 57, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R J Mc Carthy M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-13-57

PHYSICIAN'S NAME (Type): R.J. MC CARTHY, CDR, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-15-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Gawler's & Sons, 1756 Penn. Ave., N.W. Wash. D.C.
24a. REC'D BY REGISTRAR DATE: 8-12-57
24b. REGISTRAR'S SIGNATURE: Mary E Farrelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08693

CERTIFICATE OF DEATH

08691

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 1 yr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6 MANCHESTER PLACE

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 6 MANCHESTER PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHERINE — Middle — Last LANKFORD

4. DATE OF DEATH: Month AUGUST — Day 14 — Year 1957

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/1/94

9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TYPIST

10b. KIND OF BUSINESS OR INDUSTRY: Nat'l. Wildlife Fed.

11. BIRTHPLACE (State or foreign country): WISCONSIN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SERVERT RUNNING

14 MOTHER'S MAIDEN NAME: KAREN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO: 468-01-8569

17. INFORMANT: Mr. Josh E. Lankford — Address: 6 Manchester Place Silver Spring, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CARCINOMA OF THE PHARYNX — INTERVAL BETWEEN ONSET AND DEATH: 6 MOS.

148X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4-16, 1957 to 8-17, 1957 that I last saw the deceased alive on 8-14, 1957, and that death occurred at 10:5 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: L B Snow M.D. — ADDRESS (Street, city or town, state): 9013 FLOWER AVE SILVER SPRING, MD — DATE SIGNED: 8/15/57

PHYSICIAN'S NAME (Type): L. B. SNOW

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL — 22b. DATE THEREOF: 8/17/57 — 22c. NAME OF CEMETERY OR CREMATORY — 22d LOCATION (City, town, or county) (State): Menomonie, Wisconsin

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphreys — ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 8/26/57 — 24b. REGISTRAR'S SIGNATURE: Frances Fuller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15 9/5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08694

CERTIFICATE OF DEATH

08694 Reg. Dist. No 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 12 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Virginia
b. COUNTY: Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna
d. STREET ADDRESS: 217 Moore Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Celeste; Last: La Pointe

4. DATE OF DEATH: Month: August; Day: 30; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 24, 1957

9. AGE (In years last birthday) yrs: IF UNDER 1 YEAR: Months: 3; Days: 6; IF UNDER 24 HRS: Hours; Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None - Minor Child

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Virginia

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Walter G. La Pointe

14 MOTHER'S MAIDEN NAME: Teresa Keating

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO: None

17 INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RESPIRATORY ARREST — INTERVAL BETWEEN ONSET AND DEATH:

7040

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (b): Congenital Heart Disease - Tetralogy of Fallot

DUE TO (c): & Absent Left PA - 3 mo.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cardiac Surgery

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 18, 1957, to August 30, 1957, that I last saw the deceased alive on August 30, 1957, and that death occurred at 5:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore Cooper M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 8/31/57

PHYSICIAN'S NAME (Type): Theodore Cooper, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-31-57

22c NAME OF CEMETERY OR CREMATORY: Calvary Memorial Cem.

22d LOCATION (City, town, or county) (State): Fairfax Virginia

23 FUNERAL DIRECTOR'S SIGNATURE: W M Ericksburg

ADDRESS: Vienna Va.

24a REGISTRAR'S DATE: SEP 3 1957

24b REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08695 08692

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 6 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington 47X ~

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

d. STREET ADDRESS: 1006 Monroe St., N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Robert — Last: LATNEY

4. DATE OF DEATH: Month: August — Day: 13 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6 July 1879

9. AGE (In years last birthday): 78 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Humphrey LATNEY

14. MOTHER'S MAIDEN NAME: Margaret TAYLOR

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW-I

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT — Address: (Daughter) Mrs. Dorothy L. PORTER (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerotic Heart Disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 Aug. 1957 to 13 Aug. 1957 that I last saw the deceased alive on 13 Aug. 1957, and that death occurred at 9:40 P. M. from the causes and on the date stated above

SIGNATURE: August Miale Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-14-57

PHYSICIAN'S NAME (Type): August Miale, Jr. LT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-16-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Natl. Cemtery

22d. LOCATION (City town or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: MC GUIRE, 1820 9th St., N.W. Washington, D. C.

24a. REC'D BY REGISTRAR — DATE: 8-14-57

24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, [redacted]d be detached f[redacted] use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 [redacted] the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08696

08693

Reg. Dist. No. 21J

1. PLACE OF DEATH
County: Montgomery — MARYLAND
City or Town (If outside corporate limits, write RURAL and give nearest town): Kensington
Length of Stay (in this place): 9 Mo.
Hospital or Institution or Street Address: Kensington Gardens San. Kensington, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED
State: District of Columbia
County:
City or Town (If outside corporate limits, write RURAL and give nearest town):
Street Address (If rural give location): 4000 Cathedral Ave., N.W.

3. NAME OF DECEASED (Type or Print): Mary (First) E. (Middle) LEE (Last)

4. DATE OF DEATH: Aug (Month) 25 (Day) 19 57 (Year)

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Div.	Feb 22, 1875	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hswf	---	Baltimore, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Phillip Grill	Catherine Brandt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	none	P. August Grill 5211 Sho[illegible]urne Rd.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval between onset and death
IMMEDIATE CAUSE (A)	Acute Congestive Heart Failure	3 Days
ANTECEDENT CAUSE(S) DUE TO (B)	Rheumatoid Arthritis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED White at work ☐ Not white at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 23, 19 57, to Aug 25 19 57, that I last saw the deceased alive on Aug 24, 19 57, and that death occurred at 2:20 AM, from the causes and on the date stated above.

SIGNATURE AND TITLE OF M.D.: Robert T. Thibadeau, M.D.

ADDRESS (Street, city, town, state): 10609 Concord St. Kensington, Maryland

DATE SIGNED: Aug 25, 1957

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-28-1957	Loudon Park	Baltimore, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
AUG 27 1957	Frances Pettit	J. Howard Storey	3107 North Ave

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08695

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington Garden
c. LENGTH OF STAY IN 1b: 18 mo.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Kensington Garden Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Mont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 314 Ellsworth Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ~~Augusta~~ AUGUSTA Middle: DONCH Last: Lepper
4. DATE OF DEATH: Month: Aug Day: 25 Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug 6, 1863
9. AGE (In years last birthday): 94 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Washington, D. C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Henry ~~Donch~~ DONCH
14. MOTHER'S MAIDEN NAME: LOUISA BRANDT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: NONE
17. INFORMANT: Henry A. Lepper — Address: 9303 Harvey Rd. Silver Spring

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cachexia and anemia
DUE TO (b): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: unknown.
DUE TO (c): Caecal carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Dry gangrene of right foot due to arteriosclerosis.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ——— 19 52 to Aug. 25 19 57, that I last saw the deceased alive on Aug. 20 19 57, and that death occurred at 5:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: George A. Gray, Jr. M.D. — ADDRESS (Street, city or town, state): 104 Chevy Chase Dr. Chevy Chase 15, Md. — DATE SIGNED: 8/25/57

PHYSICIAN'S NAME (Type): George A. GRAY JR. M.D. Chevy Chase 15, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/28/57
22c. NAME OF CEMETERY OR CREMATORY: ROCK CREEK CEMETERY
22d. LOCATION (City, town, or county) (State): WASHINGTON, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey, — ADDRESS: SILVER SPRING, MD.
24a. REC'D BY REGISTRAR DATE: 8-30-57
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08698 08696

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY ~~Maryland~~ Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission)
a. STATE New Jersey b. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda 14, Maryland

c. LENGTH OF STAY IN 1b
6 days

c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Newark

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
The Clinical Center, Bethesda 14, Md.

d. STREET ADDRESS
314 Dayton Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Anna Middle: (No middle name) Last: Levy

4. DATE OF DEATH Month: August Day: 3 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 21, 1910

9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper

10b. KIND OF BUSINESS OR INDUSTRY: Cheese Company

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Levy

14. MOTHER'S MAIDEN NAME: Ida Weaver

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: Not available

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 min

DUE TO (b): Rh. Heart Dz & Mitral Stenosis,

DUE TO (c): A. S., Mitral Insufficiency

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? [illegible]

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from July 28, 1957, to August 3, 1957, that I last saw the deceased alive on August 3, 1957, and that death occurred at 10:50 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Carlos R. Lombardo MD

PHYSICIAN'S NAME (Type): Carlos R. Lombardo, M. D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 8/4/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Lonnegan

22b. DATE THEREOF: Aug. 5 1957

22c. NAME OF CEMETERY OR CREMATORY: AFTER FUNL. HOME

22d. LOCATION (City, town, or county) (State): NEWARK, N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: Goldberg Funeral Home

ADDRESS: 42-17-9 2-20

24a. REC'D BY REGISTRAR DATE: 8-5-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08697

08699

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1 PLACE OF DEATH
a COUNTY MONTGOMERY — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA
c. LENGTH OF STAY IN 1b 4 DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUBURBAN

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a STATE MARYLAND b COUNTY MONTGOMERY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON
d STREET ADDRESS 2813 RADIUS RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First JENNIE Middle Last LEIBLICH
4. DATE OF DEATH Month AUG Day 1 Year 1957
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH MAY 1 - 1889
9. AGE (In years last birthday) 68 yrs
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) NEW YORK
12 CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME MORDECAI ZENSTER
14 MOTHER'S MAIDEN NAME MIRIAM
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO NO
17. INFORMANT SAMUEL LEIBLICH — 8331 12th AVE SILVER SPRING

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b) Iliac vein Thrombosis — 1 wk.
DUE TO (c) Carcinoma of uterus — unkn.
174X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Acute anemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 25 1957, to Aug 1, 1957, that I last saw the deceased alive on July 31 1957, and that death occurred at 9:40 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE A. W. Danish MD — ADDRESS (Street, city or town, state) 927 Pershing Dr. Silver Spring Md — DATE SIGNED 8-1-57

PHYSICIAN'S NAME (Type) A. W. DANISH

22a BURIAL, CREMATION, REMOVAL (Specify) Burial
22b DATE THEREOF 8-3-57
22c NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery
22d. LOCATION (City, town, or county) (State) Queens, New York

23 FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE 8-1-57
24b REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

08617

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08698

Item 8 G220 2/6/57L

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. and Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Va.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Arlington
d. STREET ADDRESS: 1548 N. Edgewood
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph — Middle: — Last: Linhart

4. DATE OF DEATH: Month: Aug. — Day: 26, — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/17/07

9. AGE (In years last birthday): 50 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Linhart

14. MOTHER'S MAIDEN NAME: Jenny Ceyka

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Record — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M D

EXAMINER'S NAME (Type): Frank J. Broschart

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: Aug. 29th, 1957

22c. NAME OF CEMETERY OR CREMATORY: National Memorial Park

22d. LOCATION (City, town, or county) (State): Fairfax County, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: C. P. Swanson

ADDRESS: Arlington 1, Va.

24a. REC'D BY REGISTRAR (DATE): AUG 28 1957

24b. REGISTRAR'S SIGNATURE: J. Wilson Lobb

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08700

CERTIFICATE OF DEATH

08699

Reg. Dist. No. 215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 9 Hr. 9 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 730 Brandywine St., S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: (nmn) — Last: LOUX

4. DATE OF DEATH: Month: August — Day: 12 — Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11 August 1957

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: 9 — Min.: 9

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Raymond E. LOUX

14. MOTHER'S MAIDEN NAME: Barbara BELARDINELLI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: (Father) Raymone E. LOUX — Address: (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): IMMATURITY
DUE TO (b): PREMATURITY
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 9 HR 9 MIN

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11 August, 19 57, to 12 August, 19 57, that I last saw the deceased alive on 12 August, 19 57, and that death occurred at 8:34A. M, from the causes and on the date stated above

ACTUAL SIGNATURE: Daniel Shington M.D.
ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md.
DATE SIGNED: 8-12-57

PHYSICIAN'S NAME (Type): U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-15-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR DATE: 8-12-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08701

CERTIFICATE OF DEATH

08700

Reg. Dist. No. 17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
c. LENGTH OF STAY IN 1b:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 307 Lexington Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Sharron Nursing Home

3. NAME OF DECEASED (Type or print): First: Charles — Middle: M. — Last: Mangels

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 3, 1874

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired salesman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry Mangles

14. MOTHER'S MAIDEN NAME: Annie Buck

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO: 107-07-2573

17. INFORMANT: Herbert E. Mangles - Son — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia, thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 7 days
334X
DUE TO
(b): Coronary atherosclerosis — 10 yrs
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/16, 19 57, to 8/21, 19 57, that I last saw the deceased alive on 8/21, 19 57, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bohifant M.D. — ADDRESS (Street, city or town, state): Sandy Spring, Md. — DATE SIGNED: 8/22/57

PHYSICIAN'S NAME (Type): A. D. BOHIFANT

22a. BURIAL, CREMATION, REMOVAL (Specify): Trans. & Burial

22b. DATE THEREOF: 8/26/57

22c. NAME OF CEMETERY OR CREMATORY: GREENWOOD CEMETERY

22d. LOCATION (City, town, or county) (State): Brooklyn, New York

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: 8-22-57

24b. REGISTRAR'S SIGNATURE: Gertrude B Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08702 08701

08702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 216

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5227 Baltimore Ave.
d. STREET ADDRESS: Bethesda.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Andrew — Middle: — Last: Markhus

4. DATE OF DEATH: Month: Aug — Day: 3 — Year: 1957

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ — 8. DATE OF BIRTH: 5/13/1884 — 9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Title Exa[illegible]
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Karl Markhus
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Clara Markhus (wife) Same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour, a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/3/57
EXAMINER'S NAME (Type): Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8/7/57
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H.Hines Co.
ADDRESS: 2901 14th St., N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR DATE: AUG 5 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

VS. A1SME(S)
SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08703

CERTIFICATE OF DEATH

08702

Reg. Dist. No. 2 1C

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b: 1 month plus
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 571 E. UNIVERSITY LANE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 5 C SILVER SPRING
d. STREET ADDRESS: 900 PHILADELPHIA AVENUE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First CELESTE Middle L. Last MARSDEN

4. DATE OF DEATH: Month AUGUST Day 4 Year 19 57

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JAN. 4, 1873

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown (retired 30 yrs.)

10b. KIND OF BUSINESS OR INDUSTRY: Hotel

11. BIRTHPLACE (State or foreign country): WASHINGTON, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: (unknown) MARSDEN

14. MOTHER'S MAIDEN NAME: JANE (unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Leroy E. Hill, 900 Philadelphia Ave. Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 12-18 Mo

DUE TO (b): 1 Arteriosclerosis — ?

DUE TO (c):

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 57, to 4 Aug, 19 57, that I last saw the deceased alive on 24 July, 19 57, and that death occurred at 7:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William D. Aud M.D.

ADDRESS (Street, city or town, state): 906 Colesville Rd Silver Spring

DATE SIGNED

PHYSICIAN'S NAME (Type): WILLIAM D. AUD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/6/57

22c. NAME OF CEMETERY OR CREMATORY: CEDAR HILL CEMETERY

22d. LOCATION (City, town, or county) (State): PRINCE GEORGE COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Humphrey

ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE: 8 5 57

24b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08704 Items 2d, [illegible] Item 3: G220 9/11/57 L

CERTIFICATE OF DEATH

G220 9-17-57 et 08703 Reg. Dist. No. 296

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 4417 Chestnut Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda X2
d. STREET ADDRESS: 4417 Chestnut Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ellen Middle C Last McArdle

4. DATE OF DEATH: Month Aug. Day 28 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 9/27/1893
9. AGE (In years last birthday): 63 yrs.
If UNDER 1 YEAR: Months 11 Days 1
If UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired P.O. Clerk
10b. KIND OF BUSINESS OR INDUSTRY: P. O
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Patrick Comer
14. MOTHER'S MAIDEN NAME: Mary Fox

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Miss Irene P. Comer— Same as Item # 2 Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Circulatory Failure	
DUE TO (b)	Congestive Heart Failure	2 mos.
DUE TO (c)	Coronary Arteriosclerotic H.D.	1 yr.

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus - Gangrene Rt. leg

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1956 to Aug 28 1957 that I last saw the deceased alive on Aug 24 1957, and that death occurred at 7:00 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos F. Keliher (Keliher) M.D
ADDRESS (Street, city or town, state): 1150 Conn Ave N.W.
DATE SIGNED: 8/28/57

PHYSICIAN'S NAME (Type) Thomas F. Keliker 1150 Conn. Ave. N. W.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/31/57
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak Mt. Olivet
22d LOCATION (City town or county) (State): Washington D.C. Gaithersburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland
24a. REC'D BY REGISTRAR DATE: 9-4-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4) 1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08705 Reg. Dist. No. 08704

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Yorktowne Village
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5021 Worthington Dr.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Yorktowne Village
d. STREET ADDRESS 5021 Worthington Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Crace Middle Steiner Last Melchior
4. DATE OF DEATH Month Aug Day 23. Year 1957
5. SEX F
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Feb 4, 1864
9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR Months IF UNDER 24 HRS Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herman F. Steiner
14. MOTHER'S MAIDEN NAME Othetta Foat

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO.
17. INFORMANT Harvy W Mann Address 5021 Worthington Dr. Yorktowne Village, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) GENERALIZED ARTERIO SCLEROSIS — 20 YRS

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension, Essential moderate

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE, 1954, to 23 AUGUST, 1957, that I last saw the deceased alive on 20 AUGUST, 1957, and that death occurred at 4:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Charles E Keegan Jr. M.D. ADDRESS (Street, city or town, state) 1617 35th St. NW Wash. DC DATE SIGNED 23AUG57

PHYSICIAN'S NAME (Type) Charles E. Keegan, Jr.- 1617 35th Street, N.W.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/26/1957
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery
22d. LOCATION (City, town, or county) (State) Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The S.H.Hines Co. 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR AUG 26 57
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08706 — Reg. Dist. No. 08705 218

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Germantown
c. LENGTH OF STAY IN 1b: 6 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R-2 8 RFD # 2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N. J.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Jersey City
d. STREET ADDRESS: 571 Montgomery St
e. IS THIS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Clarence — Last: Miles

4. DATE OF DEATH: Month: Aug — Day: 13 — Year: 1957

5. SEX: Female
6. COLOR OR RACE: Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: ~~12~~ 8-19-1901
9. AGE (If over 1 year, last birthday): 55 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Clarence Crampton
14. MOTHER'S MAIDEN NAME: Emma Hamptun
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Gertrude Jackson — Address: 1820 McCulloh Balto Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M D
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): FRANK J. Broschart
DATE SIGNED: 8-13-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried
22b. DATE THEREOF: 8/17/57
22c. NAME OF CEMETERY OR CREMATORY: Poolesville,
22d. LOCATION (City, town, or county) (State): Poolesville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Sunday — ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: AUG 20 1957
24b. REGISTRAR'S SIGNATURE: Rhoda G. Cook

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08707

CERTIFICATE OF DEATH

08706

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 223 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Virginia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Triangle
d. STREET ADDRESS: Route #1, Box #14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Clarence — Last: MILLER

4. DATE OF DEATH: Month: August — Day: 27 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 24 Nov. 1893

9. AGE (In years last birthday): 63 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Marine Corps (Retired)

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas F. MILLER

14. MOTHER'S MAIDEN NAME: Nancy M. WATERS

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW-II & I

16. SOCIAL SECURITY NO: 231 22 8962

17. INFORMANT: (Wife) Mrs. Elsie M. MILLER — Address: (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma, esophagus with
DUE TO (b): generalized metastasis
DUE TO (c):

150 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 16 January, 1957, to 27 August, 1957, that I last saw the deceased alive on 27 August, 1957, and that death occurred at 12:45 PM, from the causes and on the date stated above.

ACTUAL [redacted] M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-27-57

PHYSICIAN'S NAME (Type): D.P. OSBORNE, CAPT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-30-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: [redacted] — ADDRESS: HALL Funeral Home, Occoquan, Virginia

24a. REC'D BY REGISTRAR DATE: 8-27-57
24b. REGISTRAR'S SIGNATURE: Mary C. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08707

08708

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia — COUNTY:

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)

c. LENGTH OF STAY IN 1b: 5 mos. 8 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

d. STREET ADDRESS: 2019 Eye St., N.W.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Laurence — Middle: Payson — Last: Mirick

4. DATE OF DEATH: Month: August — Day: 29 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4 February 1895

9. AGE (In years last birthday): 62 yrs

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Transportation Specialist

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George MIRICK

14. MOTHER'S MAIDEN NAME: Mary DERBY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): Yes 5-3-17 to 1-24-19

16. SOCIAL SECURITY NO.: 031-09-9400

17. INFORMANT: (Wife) Mrs. Julia K. MIRICK — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Vascular Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 months

DUE TO (b): Cerebral Arteriosclerosis — 4 years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 21 March, 1957, to 29 August, 1957, that I last saw the deceased alive on 29 August, 1957, and that death occurred at 8:30P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: August Miale Jr. M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-30-57

PHYSICIAN'S NAME (Type): August Miale, Jr., LT, MC, USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-3-57

22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery

22d LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Gawler's & Sons, 1756 Penn. Ave., N.W. Washington D. C.

24a. REC'D BY REGISTRAR DATE: 8-30-57

24b. REGISTRAR'S SIGNATURE: Mary C. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08709 08708

CERTIFICATE OF DEATH

Reg. Dist. No. 314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 1yr. 2mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Maple Lane Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 9511 Dallas Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Snowden Middle: A. Last: Mitchell

4. DATE OF DEATH: Month: 8 Day: 5 Year: 1957

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 4-12-1870

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired-Insurance

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Snowden A. Mitchell

14. MOTHER'S MAIDEN NAME: Sarah Ball

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Raymond Mitchell Address: 9511 Dallas Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.
DUE TO (b): Generalized Arteriosclerosis — 2-6 yrs.
DUE TO (c): Hemiplegia L. Syr. — 6 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour: o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 3 19 47 to Aug 3 19 57 that I last saw the deceased alive on 8-5-57 and that death occurred at 1:15 p.m. from the causes and on the date stated above.

ACTUAL SIGNATURE: Emmett Stanfield M.D. ADDRESS (Street, city or town, state): 934 Ellsworth Dr. DATE SIGNED: 8-5-57

PHYSICIAN'S NAME (Type): Reuel F. Rawlins 934 Ellsworth Dr. 8-5-57

22a. BURIAL, CREMATION, REMOVAL (Specify): burial

22b. DATE THEREOF: 8/8/57

22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

22d. LOCATION (City, town, or county) (State): Prince Georges County, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co. ADDRESS: 2901 14th St. N.W. Washington 9, D.C.

24a. REC'D BY REGISTRAR DATE: AUG 6 19

24b. REGISTRAR'S SIGNATURE: Frances Lotter

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08710

CERTIFICATE OF DEATH

08709

Reg. Dist. No. 2 17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 4 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co. General Hospital, Inc.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Airy 13 12
d. STREET ADDRESS: Rt. #3
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Sherman; Middle Maynard; Last Mullinix
4. DATE OF DEATH: Month August; Day 19; Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 21, 1899
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Poultry Farmer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: James A. Mullinix
14. MOTHER'S MAIDEN NAME: Fannie E.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Hospital Record (Wife) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cereberal Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
430.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Intracereberal Hemorrhage — 1 day
DUE TO
(c) Hypertensive Arteriosclerotic Heart Disease — Years *

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Dissecting aneurysm of aorta
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED White at work ☐ Not white at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/17, 19 57, to 8/18, 19 57, that I last saw the deceased alive on 8/18, 19 57, and that death occurred at 2:05 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: G F Meadors MD — M.D. — ADDRESS (Street, city or town, state) — DATE SIGNED: 8/20/57

PHYSICIAN'S NAME (Type): G. F. Meadors, M. D. — Damascus, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 21, 1957
22c. NAME OF CEMETERY OR CREMATORY: Poplar Springs
22d. LOCATION (City, town, or county) (State): Poplar Springs, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Chas L. Mobley with — ADDRESS: Damascus, Md.
24a. REC'D BY REGISTRAR DATE: 8-21-57
24b. REGISTRAR'S SIGNATURE: Gertrude B Fowler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08711

CERTIFICATE OF DEATH

08710

Reg. Dist. No. 277

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 11 mo

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: Edson Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Brooke Grove Foundation

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Augusta — Last: Nuber

4. DATE OF DEATH: Month: Aug. — Day: 9 — Year: 19 57

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
F	W		Dec. 23. 1878	78 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Mont. Co, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Michael Connelly
14. MOTHER'S MAIDEN NAME: Annie Frances King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO: —
17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerotic heart disease + hypertension — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-7-, 1956, to 8-9-, 1957, that I last saw the deceased alive on ——, 19——, and that death occurred at 5:04 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Bosley Ziegler M.D. — ADDRESS (Street, city or town, state): Olney — DATE SIGNED: Aug 10, 1957

PHYSICIAN'S NAME (Type): John Bosley Ziegler — Olney, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d LOCATION (City, town, or county) (State)
Burial	8/9/57	Rock Creek	Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Robert A. Pumphrey-Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: AUG 13 1957
24b. REGISTRAR'S SIGNATURE: Gertrude Sanders

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08712

CERTIFICATE OF DEATH

Reg. Dist. No. 06/6 08711

1 PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA, MD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN HOSPITAL.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: M D.
b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d STREET ADDRESS: 111 Eastmoor Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3 NAME OF DECEASED (Type or print): First: William Middle: Edward Last: Palmer

4. DATE OF DEATH: August 10 1957

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 4, 1882

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Banker (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Banking.

11. BIRTHPLACE (State or foreign country): New York State

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: VanBelt Palmer.

14 MOTHER'S MAIDEN NAME: Margaret De Many

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO: 081-16-3534

17 INFORMANT: Miss Margaret R. Palmer, Address: 111 Eastmoor Drive Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks.
DUE TO
(b): Cerebral atherosclerosis.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus and Urinary Tract Infection

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 27, 1957, to Aug. 10, 1957, that I last saw the deceased alive on Aug. 9, 1957, and that death occurred at 1.25 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James A. Roberts M.D. — ADDRESS (Street, city or town, state): 8907 Georgia Ave Silver Spring, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): JAMES A. ROBERTS, M.D.

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b DATE THEREOF: 8/12/57

22c NAME OF CEMETERY OR CREMATORY: PARKLAWN CEMETERY

22d LOCATION (City, town, or county) (State): MONTGOMERY COUNTY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey, ADDRESS: SILVER SPRING, MD.

24a REC'D BY REGISTRAR DATE: 8-13-57

24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08712

08713

CERTIFICATE OF DEATH

Reg. Dist. No. 2-17

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x1 Clarksburg
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First William — Middle Horrace — Last Pearre

4. DATE OF DEATH: Month August — Day 22 — Year 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/6/88

9. AGE (In years last birthday): 68 yrs

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Paperhanger

10b. KIND OF BUSINESS OR INDUSTRY: Home Papering

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Pearre

14. MOTHER'S MAIDEN NAME: Sally Thompson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ##### (If yes, specify war or service) #####

16. SOCIAL SECURITY NO.: 219 32 2492

17. INFORMANT — Address: Hospital Record (Wife-Lillian Pearre)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Intra-Cranial Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 days

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive-Cardio-Vascular Disease.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 17, 1957, to Aug. 22, 1957, that I last saw the deceased alive on Aug. 22, 1957, and that death occurred at 6:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacher M.D. — ADDRESS (Street, city or town, state): 26 N. Summit Ave. Gaithersburg, Md. — DATE SIGNED: 8-23-57

PHYSICIAN'S NAME (Type): J. Schumacher, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 25 57

22c. NAME OF CEMETERY OR CREMATORY: Clarksburg

22d. LOCATION (City, town, or county) (State): Clarksburg Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roy W. Barber — ADDRESS: Laytonsville, Md.

24a. REC'D BY REGISTRAR DATE: 8-26-57

24b. REGISTRAR'S SIGNATURE: Gertrude B. Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08714 **CERTIFICATE OF DEATH** Reg. Dist. No. 08713

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
c. LENGTH OF STAY IN 1b: 1½ Years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Carroll Hall Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: LeDeau Gardens Woodmoor Station, Box 657
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WINNIFRED Middle L. Last PEDERSEN
4. DATE OF DEATH: Month August Day 3 Year 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 21, 1872
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months 7 Days 12 — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Sylvester F. Hartley
14. MOTHER'S MAIDEN NAME: Agnes Wilson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Helen Warenforff — Address: 9909 Thornwood Rd. Kensington, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:

4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart disease.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 9, 1957 to Aug 2, 1957 that I last saw the deceased alive on Aug 2, 1957 and that death occurred at 3:00 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: R N. Adams M.D. — ADDRESS (Street, city or town, state): 1562 University Blvd. W. Silver Spring, Md. — DATE SIGNED

PHYSICIAN'S NAME (Type): RALSTON H. ADAMS.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Aug. 6, 1957
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Crematory
22d. LOCATION (City, town, or county) (State): Prince George Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md
24a. REC'D BY REGISTRAR DATE: 8-7-57
24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) 15M 9/55

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08715

CERTIFICATE OF DEATH

08714
Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 183 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.
d. STREET ADDRESS: 3122 Pennsylvania Avenue, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Fanie; Middle: none; Last: Politis

4. DATE OF DEATH: Month: August; Day: 30; Year: 19 57

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12 March 1887

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Greece

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Triantafylos Triantafylopoulos

14. MOTHER'S MAIDEN NAME: Constance Flesha

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: The Medical Record Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Hypertensive cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

44

~~DUE TO~~

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Severe generalized arteriosclerosis

~~DUE TO~~

(c) Diabetes mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 February 1957, to 30 August, 19 57, that I last saw the deceased alive on 30 August, 1957, and that death occurred at 12:55 p.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Floyd Rector M.D.
ADDRESS (Street, city or town, state): The Clinical Center
DATE SIGNED: 8/30/57.

PHYSICIAN'S NAME (Type): Floyd Rector, M. D.
The National Institutes of Health
Bethesda 14, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Sept 3-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town or county) (State): Suitland Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Simmons Bros
ADDRESS: Wash. D. C.

24a. REC'D BY REGISTRAR DATE: SEP 3

24b. REGISTRAR'S SIGNATURE: Bessie Thompson

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

08716

CERTIFICATE OF DEATH

08715

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 84 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Montclair
d. STREET ADDRESS: 17 Grant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Asunta; Middle: (none); Last: Postiglione

4. DATE OF DEATH: Month: August; Day: 1; Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: July 7, 1897

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11 BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael Monaco

14. MOTHER'S MAIDEN NAME: Vincenza Leone

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: Not available

17 INFORMANT: The Medical Record (Address) The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: unknown

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Metastatic carcinoma of brain — 3-4 wks.
DUE TO (c): Primary - unknown — unknown

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Macroglobulinemia

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m., 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 9, 1957, to August 1, 1957, that I last saw the deceased alive on August 1, 1957, and that death occurred at 9:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert Gordon Long M.D.
ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 8/2/57
PHYSICIAN'S NAME (Type): Robert Gordon Long, M. D.

22a BURIAL, CREMATION, REMOVAL (Specify): Burial
22b DATE THEREOF: Aug. 6, 1957
22c NAME OF CEMETERY ~~OR CREMATORY~~: Immaculate Conception
22d. LOCATION (City, town, or county) (State): Montclair, N.J.

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co.
ADDRESS: Wash., D.C.
23a. REC'D BY REGISTRAR DATE: AUG 6 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08716

08717

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 13101 Atlantic Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OREN Middle Alfred Last Prather

4. DATE OF DEATH: Month Aug Day 9 Year 1957

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/29/97

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Solomon David Prather

14. MOTHER'S MAIDEN NAME: Eva Letta Van Nuys

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Hospt records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial Infarction	1 hr.
DUE TO (b)	Coronary ~~arteriosclerosis~~ thrombosis	24 hrs
DUE TO (c)	Coronary arteriosclerosis	Indef

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1954, to 8/9/57, that I last saw the deceased alive on 8/9/57, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones, M.D. ADDRESS (Street, city or town, state): Rockville Md DATE SIGNED: 8/10/57

PHYSICIAN'S NAME (Type): Stephen N. Jones — Rockville, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/12/57

22c. NAME OF CEMETERY OR CREMATORY: Flower Hill

22d. LOCATION (City, town, or county) (State): Redland, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey-Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 8-14-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08718

CERTIFICATE OF DEATH

08717 218
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Gaithersburg
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Gaithersburg, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X/ Rural-Gaithersburg
d. STREET ADDRESS: No St. Address
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: William — Middle: Russell — Last: Rabbitt

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Dec. 9, 1892

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: 7 — Days: 23
IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: own farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: James Edward Rabbitt

14. MOTHER'S MAIDEN NAME: Ida Jane Gaither

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Charles Herman Rabbitt, same as Item #2 — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b): Arteriosclerotic Heart Disease — 4 years
DUE TO (c):

H.B.P.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan. 1, 19 57 to Aug. 1, 19 57, that I last saw the deceased alive on July 20, 19 57, and that death occurred at 4 45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Jack Schumacker M.D. — ADDRESS (Street, city or town, state): Gaithersburg, Md. 8-1-57

PHYSICIAN'S NAME (Type): Jack Schumacker — Gaithersburg, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-3-57
22c. NAME OF CEMETERY OR CREMATORY: Forest Oak Cemetery
22d. LOCATION (City, town, or county) (State): Montgomery Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: Bethesda, Maryland

24a. REC'D BY REGISTRAR — DATE: AUG 6 1957

24b. REGISTRAR'S SIGNATURE: Rhenda Cooke

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, [illegible] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08719 08718

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3920 Joliet Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 12,821 Connecticut Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RAYMOND Middle R. Last REICHARD

4. DATE OF DEATH: Month August Day 6 Year 1957

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 4, 1897

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): clerk

10b. KIND OF BUSINESS OR INDUSTRY: grocery business

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Robert Reichard

14. MOTHER'S MAIDEN NAME: Mamie Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW #1

16. SOCIAL SECURITY NO.: 578-10-0788

17. INFORMANT: Clayton B. Reichard, 3920 Joliet St., SS., Md.
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT
DUE TO
(b): Rheumatic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): ____
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Duodenal Ulcer

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug 55 to Aug 6 1957, that I last saw the deceased alive on August 6 1957, and that death occurred at 4:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bernard A Fitzgerald M.D.
ADDRESS (Street, city or town, state): 217 University Blvd E.
DATE SIGNED: 8-6-57

PHYSICIAN'S NAME (Type): Bernard A. Fitzgerald

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 9, 1957
22c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
22d. LOCATION (City, town, or county) (State): Fort Myer, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE 9/2/57

24b. REGISTRAR'S SIGNATURE: Grace Cotter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reloined by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08720

CERTIFICATE OF DEATH

08719

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 17 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 13 Georgia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Thomas — Middle — Last Ricks

4. DATE OF DEATH: Month August — Day 21 — Year 1957

5. SEX: male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1874

9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Monroe Ricks

14. MOTHER'S MAIDEN NAME: Amanda Dorsey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Zephry Ricks — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Aspiration and asphyxia — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

151x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Gastric obstruction and dilatation — 2 weeks

DUE TO (c): Obstructing gastric carcinoma

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to August 20, 1957, that I last saw the deceased alive on August 20, 1957, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Richard A. Yates M.D. — ADDRESS (Street, city or town, state): Olney Md — DATE SIGNED: 8-21-57

NAME (Type): R. A. Yates, M.D. — Olney, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/24/57

22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant.

22d. LOCATION (City, town, or county) (State): Norbeck, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden — ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: AUG 27 1957

24b. REGISTRAR'S SIGNATURE: Orlando Lawlor

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08721

08720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist No. 211

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clarksburg
c. LENGTH OF STAY IN 1b: ½ hr
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake Beach
d. STREET ADDRESS: Maryland Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Dorsey — Last: Ridgley

4. DATE OF DEATH: Month: Aug — Day: 31 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/20/09

9. AGE (In years last birthday): 47 yrs.

IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Government

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard C. Ridgley

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, ######) ######

16. SOCIAL SECURITY NO: Unknown

17. INFORMANT: Mary M. Ridgley, Address: Clarksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Carbon-Monoxide Poisoning
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Found dead in auto

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Found dead in auto with hose attached from exhaust

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) Clarksburg (County) Monty (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8-31-57

EXAMINER'S NAME (Type): FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept. 2 57

22c. NAME OF CEMETERY OR CREMATORY: Clarksburg,

22d. LOCATION (City, town, or county) (State): Clarksburg, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Roydon Barber — ADDRESS: Laytonsville. Md.

24a. REC'D BY REGISTRAR DATE: Sept 4/57

24b. REGISTRAR'S SIGNATURE: Della W. Burdette

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

08722

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08721

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Rockville
d. STREET ADDRESS: 10 Frederick Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: David — Last: Rolen

4. DATE OF DEATH: Month: Aug. — Day: 23 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1926

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lo der Oper tor

10b. KIND OF BUSINESS OR INDUSTRY: Halpine Stone Co.

11. BIRTHPLACE (State or foreign country): Saltville, Virginia

12. CITIZEN OF WHAT COUNTRY?: Americ

13. FATHER'S NAME: Grip L. Rolen

14. MOTHER'S MAIDEN NAME: Molly Coalson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Virginia Rolen — Address: Rockville, Md. 10 Frederick Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

912.2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Fracture of 1st cervical vertebrae

DUE TO (c): Fracture of hyoid. Crushed chest and pelvis — 2 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Crushed by loader machine

20c. TIME OF INJURY: Hour: 9:30 a. m. — Month, Day, Year: 8/23 1957

20d. INJURY OCCURRED: While at work ☒ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): quarry

20f. (City or town) (County) (State): Halpine Village Mont., Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/23/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-26-57
22c. NAME OF CEMETERY OR CREMATORY: Saltsville
22d. LOCATION (City, town, or county) (State): Saltsville Va

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: D.R.Henderson Funeral Home.Saltsville.Va

24a. REC'D BY REGISTRAR DATE: 8-26-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08723 **CERTIFICATE OF DEATH** 08722

Reg. Dist. No. 217

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Olney
c. LENGTH OF STAY IN 1b 49 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brooke Grove Foundation

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi Md.
d STREET ADDRESS 1936 Saratoga Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First Eugene Middle J. Last Sheehan

4. DATE OF DEATH Month August Day 3 Year 1957

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 25 1890
9. AGE (In years last birthday) 67 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman
10b KIND OF BUSINESS OR INDUSTRY G.S.A.
11. BIRTHPLACE (State or foreign country) Penna
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Michael Sheehan
14. MOTHER'S MAIDEN NAME Catherine Curran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16 SOCIAL SECURITY NO NONE
17. INFORMANT Address Eugene J Sheehan Jr

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arter. Coronary Right Sided
DUE TO (b) Renal Metastases
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: (a) 18 mos (b) 8 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Senility, Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-15, 1957, to 8-3, 1957, that I last saw the deceased alive on 7-22, 1957, and that death occurred at 4:45 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE J M Bird M.D. ADDRESS (Street, city or town, state) Sandy Spring DATE SIGNED 8/3/57
PHYSICIAN'S NAME (Type) J. M. BIRD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Aug. 6, 1957
22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven
22d LOCATION (City, town or county) Silver Spring (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Frances J. Collins ADDRESS 3821-14th St. N.W. Wash. D.C.
24a. RECD BY REGISTRAR DATE 8 6
24b. REGISTRAR'S SIGNATURE Gertrude Lawlers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08618

08723

Reg. Dist. No. 7X3

1. PLACE OF DEATH a. COUNTY: Montgomery County, MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Pa. b. COUNTY: Unknown
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park; c. LENGTH OF STAY IN 1b: Unknown	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wayne
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Washington San. & Hosp.	d. STREET ADDRESS: 318 Overhill Rd.; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print) First: Roy; Middle: William Roddeffer; Last: Shockey	4. DATE OF DEATH Month: August Day: 26 Year: 1957
5. SEX: Male; 6. COLOR OR RACE: White; 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 2-8-02; 9. AGE (In years last birthday): 55 yrs.; IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ex. Sales; 10b. KIND OF BUSINESS OR INDUSTRY: Sinclair Refining Co.	11. BIRTHPLACE (State or foreign country): D.C.; 12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: George W. Shockey	14. MOTHER'S MAIDEN NAME: Mary L. Roddeffer
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO; 16. SOCIAL SECURITY NO.: yes	17. INFORMANT: Hospital Records; Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		Interval between onset and death
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Thoracic hemorrhage	15 min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	crushed chest	
DUE TO (c)	Maniac-depressive psychosis	3 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of pelvis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.): Jumped from sun deck of hosp. (6th floor)

20c. TIME OF INJURY: 4:45 p. m.; Month, Day, Year: 8/26/57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): hospital

20f. (City or town): Takoma Park (County): Montg (State): Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/26/57

EXAMINER'S NAME (Type): Frank J. Broschart M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: 8/30/57	22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill	22d. LOCATION (City, town, or county) (State): Suitland Md
23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.	ADDRESS: 1400 Chapin St. N.W. Wash D.C.	24a. REC'D BY REGISTRAR DATE: 8/27/57	24b. REGISTRAR'S SIGNATURE: J. Watson Dodds

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08724

08724

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda 14, Maryland
c. LENGTH OF STAY IN 1b: 217 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: West Virginia — b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Moundsville
d. STREET ADDRESS: 23 Elm Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Raymond — Middle: Emerson — Last: Shook

4. DATE OF DEATH: Month: August — Day: 1 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 9, 1926

9. AGE (In years last birthday): 30 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dockman

10b. KIND OF BUSINESS OR INDUSTRY: Trucking

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry E. Shook

14. MOTHER'S MAIDEN NAME: Martha Higgins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO: 233-40-1550

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Generalized Purulent Acute Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 7 days

195 X

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Adrenal carcinoma, with metastases — 5 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from December 27, 1956 to August 1, 1957, that I last saw the deceased alive on August 1, 1957, and that death occurred at 6:10 p.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Theodore Robinson M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 8/1/57

PHYSICIAN'S NAME (Type): Theodore Robinson, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Bur-Transit

22b. DATE THEREOF: 8/4/57

22c. NAME OF CEMETERY OR CREMATORY: Halcyon Hills

22d. LOCATION (City, town, or county) (State): Sherland W. Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Robert A. Pumphrey Bethesda, Maryland

24a. REC'D BY REGISTRAR DATE: 8-3-57

24b. REGISTRAR'S SIGNATURE: Bessie M Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4) ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08725

CERTIFICATE OF DEATH

08725 Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b: 4DAYS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 2601 RANDOLPH RD.
d. STREET ADDRESS: SILVER SPRING
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First CHARLES — Middle CLINTON — Last SHREEVE

4. DATE OF DEATH: Month AUG — Day 24 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: MARCH 14-1872

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID SHREEVE

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NO.

17. INFORMANT: SON. Address: THOMAS SHREEVE - 2601 RANDOLPH RD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral confluent bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
491X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uremia and generalized arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-20, 19 57 to 8-24 19 57 that I last saw the deceased alive on 8-23 19 57 and that death occurred at 11:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Jason Geiger M.D. — ADDRESS (Street, city or town, state): 931 Pershing Drive — DATE SIGNED: 8 24 57

PHYSICIAN'S NAME (Type): JASON GEIGER M.D. Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/27/57
22c. NAME OF CEMETERY OR CREMATORY: Sandy Mount Cem.
22d. LOCATION (City, town, or county) (State): Carroll Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Wm. J. Vidmer & Sons - Balto 17 Md. — ADDRESS

24a. FILED BY REGISTRAR — DATE: AUG 27 1957 — 24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08619 **CERTIFICATE OF DEATH** 08726

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 3 days

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D.C.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital
d STREET ADDRESS: 2424 Branch Ave, S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Charles Middle None Last Smith
4. DATE OF DEATH: Month 8 Day 15 Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4-10-85
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Government Clerk
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Byron Smith
14 MOTHER'S MAIDEN NAME: La Verne Moon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Washington Sanitarium & Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Cardiac Decompensation, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Infarct, Myocardial, anterior, acute — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Arteriosclerotic Heart Disease — 10 years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour o m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from ____ 19__ to Aug 15, 1957 that I last saw the deceased alive on August 15, 1957 and that death occurred at 11:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Walcutt W. Gibson M D
ADDRESS (Street, city or town, state): 2412 Minnesota Avenue S.E.
DATE SIGNED:
PHYSICIAN'S NAME (Type): Walcutt W. GIBSON
Washington 20, D.C.

22a BURIAL, CREMATION, REMOVAL (Specify)
22b DATE THEREOF: 8-17-57
22c. NAME OF CEMETERY OR CREMATORY: Wash. National
22d. LOCATION (City, town, or county) (State): Suitland-PG-Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wm Lee & Sons
ADDRESS: Washington D.C.
24a. RECEIVED BY REGISTRAR DATE: 8/17/57
24b. REGISTRAR'S SIGNATURE: J. Wilson Rodell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Wallace W. Gibson
4912 Minnesota Avenue
Washington 20, D. C.

RECEIVED
AUG 19 1963
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08727

08620

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Va. b. COUNTY Fairfax
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oak Grove Farm; Clifton, Va.
d. STREET ADDRESS 83X
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Earl Middle Jerome Last Smith
4. DATE OF DEATH Month 8 Day 1 Year 1957

5. SEX M
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 7-15-00
9. AGE (In years last birthday) 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman
10b. KIND OF BUSINESS OR INDUSTRY Cemetery
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John A. Smith
14. MOTHER'S MAIDEN NAME Stella Patton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 577-12-7356
17. INFORMANT Address Washington Sanitarium & Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Hypostatic pneumonia	8 hours
DUE TO (b)	Massive gastro intestinal hemorrhage	24 hours
DUE TO (c)	Carcinoma of head of pancreas	6 months

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1957 to 8-1-57, 19___, that I last saw the deceased alive on 8-1-57, 19___, and that death occurred at 11:15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE Arthur E Coyne M.D.
ADDRESS (Street, city or town, state) 7600 Carroll Ave Takoma Park Md
DATE SIGNED

PHYSICIAN'S NAME (Type) Arthur E Coyne MD

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-4-57
22c. NAME OF CEMETERY OR CREMATORY National Memorial Park
22d. LOCATION (City, town, or county) Falls Church (State) VA

23. FUNERAL DIRECTOR'S SIGNATURE J. W. Lee
ADDRESS Wash. D.C.
24a. REC'D BY REGISTRAR DATE AUG 5 1957
24b. REGISTRAR'S SIGNATURE J Wilson Doddy

For Everly Funeral Home; Fairfax, Va.
Olney, Md.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08726 Item 21 [illegible] 08728

CERTIFICATE OF DEATH

Reg. Dist. No. 2/6

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 314 Franklin Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Bryan — Last: Smith

4. DATE OF DEATH: Month: August — Day: 20 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 21 April 1898

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seafood broker

10b. KIND OF BUSINESS OR INDUSTRY: Brokerage

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Perry Smith

14. MOTHER'S MAIDEN NAME: Ida Pruitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): yes (If yes, give war or date of service): 1916

16. SOCIAL SECURITY NO: Unascertainable

17. INFORMANT: The Medical Record — Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): cirrhosis of the liver — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): bleeding duodenal ulcer

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7 August, 1957, to 20 August, 1957, that I last saw the deceased alive on 20 August, 1957, and that death occurred at 12:45 P.M., from the causes and on the date stated above

ACTUAL SIGNATURE: Thomas C Bithell M.D
ADDRESS (Street, city or town, state): The Clinical Center, The National Institutes of Health, Bethesda 14, Maryland
DATE SIGNED: 8/20/57
PHYSICIAN'S NAME (Type): THOMAS C. BITHELL, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/23/57
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: The S.H. Hines Co.-2901 14th St., N.W.
ADDRESS: Wash. D.C.

24a. REC'D BY REGISTRAR: DATE: AUG 23 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 [illegible] should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 [illegible] 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08621

CERTIFICATE OF DEATH

08729
Reg. Dist. No. 223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington Sanitarium & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington
d. STREET ADDRESS: 3611 Dupont Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Reinhold; Middle: Paul; Last: Springirth

4. DATE OF DEATH: Month: August; Day: 24; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-19-71

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Caretaker

11. BIRTHPLACE (State or foreign country): D. C.

12. CITIZEN OF WHAT COUNTRY? U.S. America

13. FATHER'S NAME: ? Springirth

14. MOTHER'S MAIDEN NAME: (unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Navy

16. SOCIAL SECURITY NO.: [redacted]

17. INFORMANT: Hospital Records
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Arteriosclerotic Heart Disease — 10+ years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from August 21, 1957, to August 24, 1957, that I last saw the deceased alive on August 24, 1957, and that death occurred at 2:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward A. Beeman M.D.
ADDRESS (Street, city or town, state): 10620 Georgia Ave Silver Spring
DATE SIGNED: 5-24-57

PHYSICIAN'S NAME (Type): Edward A. Beeman
10620 Georgia Ave., Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/27/57
22c. NAME OF CEMETERY OR CREMATORY: Prospect Hill
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey
ADDRESS: Bethesda, Md.

24a. RECEIVED BY REGISTRAR
DATE: 8/27/57

24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08730

Reg. Dist. No. 217

~~State File No.~~ 08727

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sandy Spring
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): ~~Lena~~ HELEN — First — Janney — Middle — Stabler — Last

4. DATE OF DEATH: Month: Aug. — Day: 14 — Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1869

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): Lincoln, Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bernard T. Janney

14. MOTHER'S MAIDEN NAME: Isabella S. BOWNE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT — Address: Mrs. Lofton S. Wesley, Sandy Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Malnutrition and cachexia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

DUE TO (b): Intestinal obstruction (sigmoid colon) — 7 months

DUE TO (c): by metastases from Paget's disease of nipple with intraductal carcinoma — 3 years

170 x

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 22, 1957, to Aug 12, 1957, that I last saw the deceased alive on Aug. 12, 1957, and that death occurred at 5 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R Stephen Hulburt, M.D. — ADDRESS (Street, city or town, state): 3000 Dent Place, NW — DATE SIGNED: Aug 14 1957

PHYSICIAN'S NAME (Type): R. Stephen Hulburt, M.D. Washington 7, D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION

22b. DATE THEREOF: 8/17/57

22c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN CREMATORY

22d. LOCATION (City, town, or county) (State): PRINCE GEORGE CO., MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: Wilmer E. Humphrey — ADDRESS: Silver Spring, Md.

24a. REC'D BY REGISTRAR DATE: 8-19-57

24b. REGISTRAR'S SIGNATURE: Gertrude B Fowler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and [illegible] to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A1SME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08728

08731

Reg. Dist. No. 2

1 PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b: 3½ yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 1911 Carmody Drive

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 1911 Carmody Drive
e. IF NOT IN CITY, ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jane — Middle: Ann — Last: Stark
4. DATE OF DEATH: Month: August — Day: 17 — Year: 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: March 13, 1861
9. AGE (In years last birthday): 96 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): London, Onterio
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Alexander McKinnon
14. MOTHER'S MAIDEN NAME: Margaret Topping
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: Mrs. W. Frank Clucas, 1911 Carmody Dr. Address: Silver Spring, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b): Cerebral Vascular Accident — 8 mo
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M.D.
EXAMINER'S NAME (Type): Frank J. Broschart, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8-17-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8/19/57
22c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
22d. LOCATION (City, town, or county) (State): Hyattsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey
ADDRESS: Silver Spring, Md.
24a. REC'D BY REGISTRAR DATE: 8-26-57
24b. REGISTRAR'S SIGNATURE: Frances Fuller

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08729 Item 3 rev. 1 8-6-57 08732

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital, Bethesda, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: St. Mary's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hollywood (Rural)
d. STREET ADDRESS: Route #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arnie; Middle: Wilber; Last: STEPHENS

4. DATE OF DEATH: Month: August; Day: 3; Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 18, 1920

9. AGE (In years last birthday): 37 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mariner

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Navy

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Willie Ware STEPHENS

14. MOTHER'S MAIDEN NAME: Laura MC KINNEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 3-6-39 - 8-3-57

16. SOCIAL SECURITY NO: 226-09-3083

17. INFORMANT: (Wife) Mrs. Maggie Cora STEPHENS (Same as #2) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 29, 1957, to August 3, 19 57, that I last saw the deceased alive on August 3, 19 57, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Bruce H. Rice M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-3-57

PHYSICIAN'S NAME (Type): Bruce H. RICE, LT,MC,USN — U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-5-57
22c. NAME OF CEMETERY OR CREMATORY: Private Cemetery
22d. LOCATION (City, town, or county) (State): Danville, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.

24a. REC'D BY REGISTRAR — DATE: 8-3-57
24b. REGISTRAR'S SIGNATURE: Barry C. Farrelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08730

CERTIFICATE OF DEATH

08733

Reg. Dist. No. 216

1 PLACE OF DEATH
a. COUNTY Suburban Montgomery MAR[redacted]
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda
c. LENGTH OF STAY IN 1b 67 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda x3
d STREET ADDRESS 4529 Windsor Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Edith Middle Virginia Last STEPHENS
4. DATE OF DEATH Month 3 Day 17 Year 1957
5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-4-88
9. AGE (In years last birthday) 68 yrs
IF UNDER 1 YEAR Months 8 Days 13 IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY — — —
11. BIRTHPLACE (State or foreign country) Maryland.
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME ? James GRAY
14. MOTHER'S MAIDEN NAME Elizabeth? HAYS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO NO
17. INFORMANT Dorothy Mohler Address 6145 9th Ave. Cap. Heights, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Myocarditis + Mod.	4 mos.
DUE TO (b)	Arteriosclerosis, generalized	?
DUE TO (c)	Cerebral thrombosis + paralysis	4 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 2 July, 1957, to 16 Aug, 1957, that I last saw the deceased alive on 16 Aug, 1957, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Herbert Martyn Jr. M.D
ADDRESS (Street, city or town, state) 5029 Bethesda Ave.
DATE SIGNED 16 Aug 57

PHYSICIAN'S NAME (Type) HERBERT MARTYN Jr. 5029 Bethesda Ave. Bethesda, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/19/1957
22c. NAME OF CEMETERY OR CREMATORY Monocacy
22d. LOCATION (City, town, or county) (State) Montgomery Co. Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Robert A. Pumphrey-7557 Wis. Ave. Bethesda,
24a. REC'D BY REGISTRAR DATE Md. 8-22-57
24b. REGISTRAR'S SIGNATURE Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page [redacted] be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08622 **CERTIFICATE OF DEATH** 08734

Reg. Dist. No. 223

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 14 hrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Washington San. + Hosp.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
d. STREET ADDRESS: 2606 Hughes Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Stout

4. DATE OF DEATH: Month: Aug. — Day: 1 — Year: 1957

5. SEX: Fe
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 4/27/75
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): N J
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Aaron Newman
14. MOTHER'S MAIDEN NAME: Neaves

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Hosp Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Spontaneous pneumoperitoneum ~~rupture of stomach~~ — INTERVAL BETWEEN ONSET AND DEATH: 15 min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Rupture of stomach
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d INJURY OCCURRED: While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 31, 1957, to August 1, 1957, that I last saw the deceased alive on July 31, 1957, and that death occurred at 7:50 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Bennet A. Porter, Jr. M.D. — ADDRESS (Street, city or town, state): 9301 Colesville Rd., Silver Spring, Md. — DATE SIGNED: Aug 1, 57

PHYSICIAN'S NAME (Type):

22a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-2-1957
22c. NAME OF CEMETERY OR CREMATORY: Monmouth Memorial Park
22d. LOCATION (City, town, or county) (State): New Shrewsbury, N.J.

23 FUNERAL DIRECTOR'S SIGNATURE: Joseph L. Lauter Sons — ADDRESS: 1756 Pa. Ave. N.W. D.C.
24a. REC'D BY REGISTRAR DATE: 8/3/57
24b REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08731

CERTIFICATE OF DEATH

Reg. Dist. No. 08735/4

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 10512 Kinloch Road (Hillendale)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10512 Kinloch Rd. (Hillendale)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Belle; Last: Stultz

4. DATE OF DEATH: Month: August; Day: 16; Year: 19 57

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 12, 1874

9. AGE (In years last birthday): 74 82 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Woodstock, Va.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John W. Baker

14. MOTHER'S MAIDEN NAME: Frances Copp

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: John S. Stultz — Address: 10512 Kinloch Rd. Silver Spg. Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Coronary Thrombosis (New) — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b): Coronary Thrombosis (old) — Nov 1954 Apr 1955 May 1955

DUE TO (c): Arteriosclerotic Heart Disease — Undetermined

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 22 19 57 to Aug 16 19 57 that I last saw the deceased alive on Aug 15 19 57 and that death occurred at 6:25 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: George L Ball M.D. — ADDRESS (Street, city or town, state): 7835 Eastern Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): George L. Ball — Silver Spring Md — Aug 16 1957

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/19/57

22c. NAME OF CEMETERY OR CREMATORY: Massanutten Cemetery

22d. LOCATION (City, town, or county) (State): Woodstock, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: The S. H. Hines Co. Washington, D. C.

24a. REC'D BY REGISTRAR (DATE): AUG 20 1957

24b. REGISTRAR'S SIGNATURE: Frances Pettey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [redacted] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

08623 — Reg. Dist. No. 08736 213

1. PLACE OF DEATH
a. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
c. LENGTH OF STAY IN 1b: 11 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7114 Popular Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 Takoma Park
d. STREET ADDRESS: 7114 Popular Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ella — Middle: D — Last: Sussex
4. DATE OF DEATH: Month: 8/12/57 — Day — Year: 19
5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/14/65
9. AGE (In years last birthday): 91 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Canada
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Dilzell
14. MOTHER'S MAIDEN NAME: NOT KNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marguerite S. Terry — Address: Item 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 704.9 Fracture of rt. hip June 1957
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18):
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart, M.D.
EXAMINER'S NAME (Type): Frank J Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/12/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug. 14, 1957
22c. NAME OF CEMETERY OR CREMATORY: George Washington Cemetery
22d. LOCATION (City, town, or county) (State): Prince George County Md

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Arthur Walters, 24 Carroll St. NW DC
24a. REC'D BY REGISTRAR DATE: 7/15/57
24b. REGISTRAR'S SIGNATURE: [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 shall be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS A1SME 5M 2 57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08732

CERTIFICATE OF DEATH

08737 217
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney

c. LENGTH OF STAY IN 1b: 12 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg,

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Montgomery County General Hospital

d. STREET ADDRESS: Rt. #2

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Willnett Middle Last Tates

4. DATE OF DEATH: Month August Day 15 Year 19 57

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11/23/04

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Work (Domestic)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Hospital Record

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

590 X

DUE TO (b): Malignant Hypertension — 1 month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Acute Nephritis — 1 month

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/1, 19 57 to 8/13, 19 57 that I last saw the deceased alive on 8/14, 19 57, and that death occurred at 8:13 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: G F Meadors M.D.

PHYSICIAN'S NAME (Type): G. F. Meadors, M. D. Damascus, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/19/57

22c. NAME OF CEMETERY OR CREMATORY: Brooke Grove,

22d. LOCATION (City, town, or county) (State): Laytonsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.

24a. REC'D BY REGISTRAR DATE: AUG 20

24b. REGISTRAR'S SIGNATURE: Gertrude Lawler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08733 08738 21

CERTIFICATE OF DEATH

Reg. Dist. No. 131

1 PLACE OF DEATH
a. COUNTY: Montgomery ~~Prince Georges~~ — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattstown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattstown
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FREDERICK — Middle DELOS — Last THOMPSON, SR.
4. DATE OF DEATH: Month August — Day 12, — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 25, 1889
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Y.M.C.A.
10b. KIND OF BUSINESS OR INDUSTRY: Sec.
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hiram Thompson
14. MOTHER'S MAIDEN NAME: Layra B. Reed

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 119-26-1001
17. INFORMANT: Address: Mrs. Eva H. Thompson, Hyattstown, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours
3.10 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): (2) Hypertension — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from 8-11-, 1957 to 8-11-, 1957 that I last saw the deceased alive on 8-11-, 1957, and that death occurred at 7:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rex R. Martin M.D. — ADDRESS (Street, city or town, state): 35 E. Church Frederick Md — DATE SIGNED: 8-11-57

PHYSICIAN'S NAME (Type): Dr. Rex R. Martin

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: Aug. 13, 1957
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Crematory
22d. LOCATION (City, town, or county) (State): Bladensburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: M. R. Etchison & Son, Frederick, Maryland
24a. DEPUTY REGISTRAR'S DATE: AUG 15 1957
24b. REGISTRAR'S SIGNATURE: Hilda Brandenburg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1

08734

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Fi... 8-1-57 et

08740

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 7161 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: The Clinical Center, Bethesda 14, Md.

2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 4416 Clearfield Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Donald; Middle Howard; Last Urso

4. DATE OF DEATH: Month August; Day 6; Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: August 7, 1950

9. AGE (In years last birthday): 6 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph H. Urso

14. MOTHER'S MAIDEN NAME: Roberta Kilby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: The Medical Record
Address: The Clinical Center, Bethesda 14, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute ulceration Ileum & Massive Gastrointestinal

DUE TO: Hemorrhage

204.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Leukemia, acute, lymphocytic

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 27, 1957 to August 6, 1957, that I last saw the deceased alive on August 6, 1957, and that death occurred at 11:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Roger Lester M.D.

ADDRESS (Street, city or town, state): The Clinical Center, National Institutes of Health, Bethesda 14, Maryland

DATE SIGNED: 8/6/57

PHYSICIAN'S NAME (Type): Roger Lester, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/9/57

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NAT'L. CEMETERY

22d. LOCATION (City, town, or county) (State): ARLINGTON, VIRGINIA

23. FUNERAL DIRECTOR'S SIGNATURE: Warner C. Turnbaugh

ADDRESS: SILVER SPRING, MD.

24a. REC'D BY REGISTRAR DATE 8-8-57

24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08735

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08741

Reg. Dist. No. 215

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Ohio
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cleveland

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): U.S. Naval Hospital, Bethesda, Maryland
d. STREET ADDRESS: 13914 Benwood Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ronald — Middle: Joseph — Last: WACHOWSKI

4. DATE OF DEATH: Month: August — Day: 31 — Year: 19 57

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 17 Dec. 1936

9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months: — Days:
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Edward WACHOWSKI

14. MOTHER'S MAIDEN NAME: Sophie CHUDZIK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes, Currently

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: (Mother) Mrs. Sophie WACHOWSKI (Same As #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 28 hours

823X

DUE TO (b): Fracture of Skull

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Multiple Fractures of Face

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Was driver of auto which failed to make curve on highway

20c. TIME OF INJURY Hour: 2:00 A.M. P.M. — Month, Day, Year: Aug. 30 57

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street

20f. (City or town) Arlington, (County) Arlington, (State) Virginia

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Frank J. Broschart M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 8-31-57

EXAMINER'S NAME (Type): Frank J. Broschart, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 9-4-57

22c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

22d LOCATION (City, town, or county) (State): Cleveland, Ohio

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: R. A. Pumphrey, 4701 Wisconsin Ave., Bethesda, Md

24a. REC'D BY REGISTRAR DATE: 8-31-57

24b. REGISTRAR'S SIGNATURE: Mary L. Farrelly

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08742

08736 **CERTIFICATE OF DEATH** Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY: Montgomery MARYLAND
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Olney
c. LENGTH OF STAY IN 1b: 2 hrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): xo Olney
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Montgomery Co. General Hospital
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Baby Middle: Last: Washington
4. DATE OF DEATH Month: August Day: 26 Year: 19 57

5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 8/26/57
9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours: 2 Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Newborn
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Virginia I. Washington

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Hospital Record (Mother) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gross [illegible] – 4 of body
116X
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/26, 1957, to 8/26, 1957, that I last saw the deceased alive on 8/26, 1957, and that death occurred at 9:15PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: A. D. Bonifant M.D. ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): A. D. Bonifant, M. D. Sandy Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/57
22c. NAME OF CEMETERY OR CREMATORY: Lincoln Park,
22d. LOCATION (City, town, or county) (State): Rockville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR DATE: SEP 4 1957
24b. REGISTRAR'S SIGNATURE: Gertrude Luberg

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FOR STATE HEALTH-DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08737

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08743

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 10 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Suburban Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gaithersburg
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Washington — Last:
4. DATE OF DEATH: Month: Aug. — Day: 27, — Year: 1957

5. SEX: male
6. COLOR OR RACE: col.
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11/8/23
9. AGE (In years last birthday): 33 yrs
IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lee Washington
14. MOTHER'S MAIDEN NAME: Henrietta Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO:
17. INFORMANT: Address: Henrietta Washington, Gaithersburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage & laceration
DUE TO (b): Multiple compound fractures of skull
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH: 10 hrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of rt forearm

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Struck by freight train at B & O crossing
20c. TIME OF INJURY: Hour 7:25 p. m. — Month, Day, Year: 8/26 '57
20d. INJURY OCCURRED: White at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RR Crossing
20f. (City or town) (County) (State): Gaithersburg, Montg. Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Frank J. Broschart M.D.
EXAMINER'S NAME (Type): Frank J. Broschart
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/27/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/30/57
22c. NAME OF CEMETERY OR CREMATORY: Arlington National,
22d. LOCATION (City, town, or county) (State): Arlington, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden
ADDRESS: Rockville, Md.
24a. REC'D BY REGISTRAR: SEP 3 1957
24b. REGISTRAR'S SIGNATURE: Bessie Thompson

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM's. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

VS A15M
5M 2'57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08738 08744

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SILVER SPRING
d. STREET ADDRESS: 10202 MENLO AVE.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE Middle M Last WHIPPLE, Sr.

4. DATE OF DEATH: Month Aug Day 9 Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 25, 1872

9. AGE (In years last birthday): 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Store Employee

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Calvin Whipple

14. MOTHER'S MAIDEN NAME: Satira Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Gertrude M. Whipple — Address: 10202 Menlo Silver Spg Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Decompensation (acute) — INTERVAL BETWEEN ONSET AND DEATH: 1 — 2 days
DUE TO
4000
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b): Arteriosclerosis
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pyloric Stenosis (from old duodenal ulcer)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/1, 1957, to 8/9, 1957, that I last saw the deceased alive on 7/24, 1957, and that death occurred at 9:12 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William D. Aud, M.D. — ADDRESS (Street, city or town, state): 906 Adelphi Rd Silver Spring Md — DATE SIGNED:

PHYSICIAN'S NAME (Type): WILLIAM D AUD

22a. BURIAL, CREMATION, OR REMOVAL (Specify): Cremation
22b. DATE THEREOF: 8-12-57
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Md

23. FUNERAL DIRECTOR'S SIGNATURE: Neal Funeral Home — ADDRESS: 4812 Hamilton Ave Hyattsville

24a. REC'D BY REGISTRAR DATE: AUG 14 1957
24b. REGISTRAR'S SIGNATURE: Frances Potter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08624 **CERTIFICATE OF DEATH** 08745

Reg. Dist. No. 223

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Pk. Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Leush Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: District of Columbia
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington, D C
d. STREET ADDRESS: 7410 Georgia Ave NW
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leslie Middle: Thomas Last: White

4. DATE OF DEATH: Month: Aug Day: 26 Year: 1957

5. SEX: Male

6. COLOR OR RACE: Caus.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-30-XXX 1909

9. AGE (In years last birthday): 48 yrs

If UNDER 1 YEAR: Months: 1 Days: Hours: Min:
IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi Operator

10b. KIND OF BUSINESS OR INDUSTRY: Diamond Cab Co.

11. BIRTHPLACE (State or foreign country): N. C.

12. CITIZEN OF WHAT COUNTRY? American

13. FATHER'S NAME: Thomas White

14. MOTHER'S MAIDEN NAME: Bessie Aldridge

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-03-8718

17. INFORMANT: Chart a wife, Address: 7410 Ga. Ave., Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 12 hour

420.1

DUE TO (b): Infarct Myocardium Left ventricle — 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Coronary Thrombosis — 2 days

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year, Hour o m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 12-22- 1941 to 8-26- 1957 that I last saw the deceased alive on 8-26-57 19 and that death occurred at 4:01 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: W. Shoemaker M.D. — ADDRESS (Street, city or town, state): 8005 Woodbury Drive — DATE SIGNED

PHYSICIAN'S NAME (Type): W.C. SHOEMAKER. MD. — Silver Spring, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): TRANS. & BURIAL 8/29/57

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: SHADY GROVE CEMETERY

22d. LOCATION (City, town or county) (State): DUNN, NORTH CAROLINA

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E. Pumphrey — ADDRESS: SILVER SPRING, MD.

24a. RECEIVED BY REGISTRAR DATE: 9/28/57

24b. REGISTRAR'S SIGNATURE: J. Wilson Dodd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08739

CERTIFICATE OF DEATH

08747

Reg. Dist. No. 216

1. PLACE OF DEATH
a. COUNTY: MONTGOMERY — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BETHESDA
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION: SUBURBAN

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: DISTRICT — b. COUNTY: COLUMBIA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 4813 DAVENPORT ST. NW.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First BENJAMIN — Middle RAWTON — Last WILLIAMSON

4. DATE OF DEATH: Month Aug — Day 18 — Year 1957

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 17 - 1894

9. AGE (In years last birthday): 63 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RAILROAD MAIL CLERK

10b. KIND OF BUSINESS OR INDUSTRY: P.O. DEPT.

11. BIRTHPLACE (State or foreign country): N. CAROLINA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: PAGE WILLIAMSON

14. MOTHER'S MAIDEN NAME: MARGARET BURKE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: NO

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Exsanguination
DUE TO
541.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Bleeding Duodenal ulcer — INTERVAL BETWEEN ONSET AND DEATH: 24 Hours
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 1953 to Aug 17 1957, that I last saw the deceased alive on Aug 17 1957, and that death occurred at 10:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: C P Ryland M.D. — ADDRESS (Street, city or town, state): 4400 - 49 St. NW. Washington DC — DATE SIGNED

PHYSICIAN'S NAME (Type): CHARLES P. RYLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Buried — 22b. DATE THEREOF: 8/20/57 — 22c. NAME OF CEMETERY OR CREMATORY: Glenwood Cem. — 22d LOCATION (City, town or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Chas. Chamberlain Funeral Home — ADDRESS: 5100 Nic Ave NW. — 24a REC'D BY REGISTRAR DATE: 8-26-57 — 24b REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08740

CERTIFICATE OF DEATH

08748

Reg. Dist. No. 24

1. PLACE OF DEATH
a. COUNTY: Montgomery Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NORBECK MD.
c. LENGTH OF STAY IN 1b: 21 Months.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PHILOMENA REST HOME.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Wash. — b. COUNTY: D.C.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington D.C. + N.E.
d. STREET ADDRESS: 1209 Holly St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOHN L — Middle — Last WISE
4. DATE OF DEATH: Month 8/26/57 — Day — Year 19

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: OCT 11 1887
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED.
10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOV'T.
11. BIRTHPLACE (State or foreign country): VA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES B WISE.
14. MOTHER'S MAIDEN NAME: LUELLA ARMENTROUT.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT — Address: Mrs Grace W Morrison. Dayton Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): BRONCHOGENIC CARCINOMA, RIGHT LUNG — INTERVAL BETWEEN ONSET AND DEATH: 2yrs
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept 23, 19 55, to Aug 26, 19 57, that I last saw the deceased alive on Aug 25, 19 57, and that death occurred at 3.15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm F Greaney MD — M.D. — ADDRESS (Street, city or town, state): 7342 12th St NW Wash D.C. — DATE SIGNED: Aug 26, 1957

PHYSICIAN'S NAME (Type): WM F GREANEY MD 7342 12TH ST NW WASH D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial.
22b. DATE THEREOF: 8/28/57
22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cem.
22d LOCATION (City, town, or county) (State): Pr Georges Co Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W A Gunteman & Son — ADDRESS: 5732 Georgia Ave N.W.
24a. REC'D BY REGISTRAR — DATE: 8/30/57
24b. REGISTRAR'S SIGNATURE: Frances Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08741 08749

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH
a. COUNTY: Montgomery County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda
c. LENGTH OF STAY IN 1b: 24 days.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Suburban Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rockville
d. STREET ADDRESS: 11409 Grayling Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: M. — Last: Wynkoop

4. DATE OF DEATH: Month: August — Day: 6 — Year: 19 57

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feburary 11, 1884
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Washington D. C.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Mitchell Wells
14. MOTHER'S MAIDEN NAME: Gardiner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Edna Mae Walton (daughter), 11407 Grayling Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Myocardial infarction	24 days
DUE TO (b)	Coronary thrombosis	24 days
DUE TO (c)	Coronary A.S. H.D.	Indef.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1, 1957, to 8/6/, 1957, that I last saw the deceased alive on 8/6/, 1957, and that death occurred at 3:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Stephen N. Jones, M.D. — ADDRESS (Street, city or town, state): Rockville Md. — DATE SIGNED: 8/6/57

PHYSICIAN'S NAME (Type): Stephen N. Jones

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8/9/57
22c. NAME OF CEMETERY OR CREMATORY: Congressional Cemetery
22d. LOCATION (City, town, or county) (State): Washington, D. C.

23. FUNERAL DIRECTOR'S SIGNATURE: Warner E Pumphrey — ADDRESS: 8434 Ga 5576
24a. REC'D BY REGISTRAR — DATE: 8-9-57
24b. REGISTRAR'S SIGNATURE: Bessie M. Thompson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after decedent

VS A15 (4)
15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C8625

08750

Reg. Dist. No. 773

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY P.G.

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park

c. LENGTH OF STAY IN 1b DOA

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Langley Park 16 x 2.2

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington San. and Hospital

d. STREET ADDRESS 1407½ Merimack Dr.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print) First Hattie Middle Young Last

4. DATE OF DEATH Month 8/12/57 Day Year 19

5. SEX female

6. COLOR OR RACE col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 10/10/11

9. AGE (In years last Birthday) 45 yrs.

IF UNDER 1 YEAR: Months Days

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY At Home

11. BIRTHPLACE (State or foreign country) Caledonia, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alexander Scott

14. MOTHER'S MAIDEN NAME Emma Moran

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Hospital Record

0

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

2

ACTUAL SIGNATURE Frank J. Broschart M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED 8/12/57

EXAMINER'S NAME (Type) Frank J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 8-16-57

22c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery

22d. LOCATION (City, town, or county) (State) Rockville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Henry S. Washington & Son 467 K St. N.W.

24a. REC'D BY REGISTRAR DATE AUG 16 1957

24b. REGISTRAR'S SIGNATURE J. Wilson Addy

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AISME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08742

CERTIFICATE OF DEATH

08751 215
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1. PLACE OF DEATH
a. COUNTY: Montgomery — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bethesda (Rural)
c. LENGTH OF STAY IN 1b: 50 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: U.S. Naval Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rison (Rural)
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Lillian; Middle: Cobb; Last: YOUNG

4. DATE OF DEATH: Month: August; Day: 25; Year: 1957

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: January 25, 1906
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Califronia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lawrence Arthur COBB
14. MOTHER'S MAIDEN NAME: Rosemarie AMBROSE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Oliver L. YOUNG (Husband), (Same as #2) — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, left lower lung — INTERVAL BETWEEN ONSET AND DEATH: 7 days
162x
DUE TO (b): Bronchogenic Carcinoma — 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 1957, to August 25, 1957, that I last saw the deceased alive on August 25, 1957, and that death occurred at 3:14 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. B. Ingram M.D. — ADDRESS (Street, city or town, state): U.S. Naval Hospital, Bethesda, Md. — DATE SIGNED: 8-26-57

PHYSICIAN'S NAME (Type): William B. Ingram, CDR, MC, USN U.S. Naval Hospital, Bethesda, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-30-57
22c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cemetery
22d. LOCATION (City, town, or county) (State): Arlington, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE: Robert A. Pumphrey — ADDRESS: R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Md.
24a. REC'D BY REGISTRAR — DATE: 8-26-57
24b. REGISTRAR'S SIGNATURE: Mary E. Farrelly